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UNIVERSITY OF ALBERTA

# THE INFLUENCE OF THE ALBERTA ASSOCIATION OF REGISTERED NURSES ON HEALTH CARE SERVICES AND HEALTH CARE POLICY FROM 1916 TO 1950

BY

MARY ELIZABETH JOY MYSKIW

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of MASTER OF NURSING.

FACULTY OF NURSING

Edmonton, Alberta

SPRING, 1992

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UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled The Influence of the Alberta Association of Registered Nurses on Health Care Services and Health Policy from 1916 to 1950 submitted by Mary Elizabeth Joy Myskiw in partial fulfillment of the requirements for the degree of Master of Nursing.

Dr. J. R. Kerr

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April 21, 1992

Abstract

This historical study examined the influence the Alberta Association of Registered Nurses [AARN] had on health care services and health policy in Alberta from 1916 to 1950. The development of the AARN as a profession was traced considering four criteria as essential: autonomy, skill and knowledge, service ideal, and formal code of ethics. The status of women was examined as it seemed inextricably linked to the status of nurses and therefore the development of the nursing profession. A holistic meaning of health was used to examine Alberta legislation that related to health policy and the subsequent health care services. To interpret the activities of the AARN in a total historical context some external events were identified and discussed. Three of the catalysts of health reform that were identified were epidemics of communicable diseases, social upheaval of the world wars, and economic depressions. From 1916 to 1950 the AARN appeared to have influenced health care services, particularly as they related to the work of nurses, but had no direct observable influence on health policy in Alberta.

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# Chapter I

## Studying the Nursing Profession: Statement of Problem and Method

In reviewing the situation of nurses in Alberta hospitals, the Premier's Commission on Future Health Care for Albertans wrote, "The concerns of nurses appear to be symptomatic of a larger issue--nurses feel they have little influence on the major decisions which affect their daily activities." [1] One of the focuses of this Commission upon its creation was to address nursing concerns which have recently come to the attention of the public as a result of political action by nurses. The findings of the Commission regarding the influence nurses felt they had in major decisions is a comment on both government and nursing. As Adelaide Nutting wrote in 1926, "In the last analysis the great improvements in nursing must come from within: they must be brought about by nurses for nurses....Sharing the privileges of the whole body, you must inevitably share their difficulties and responsibilities." [2] This observation led the investigator to consider the history of organized nursing in Alberta, and the following research question: What influence has the Alberta

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[1] Premier's Commission on Future Health Care for Albertans. (1988). Caring and commitment (Interim report). Edmonton: Government of Alberta, p. 1.

[2] Nutting, M. A. (1926). Nursing and public health. In M. A. Nutting (Ed.). A sound economic basis for schools of nursing. New York: Putnam's Sons, p. 153.

Association of Registered Nurses [AARN] had on health care services and health policy in Alberta from 1916 to 1950? Before addressing the research question, it is essential to define some fundamental concepts in this study.

## Nature of Man and Culture

In analyzing the influence of the AARN during the study period it was necessary to identify philosophical assumptions regarding the nature of man and culture. Wallace's definition of nature was used in this thesis: "Nature...is what is free from human intervention and artifice, what comes into being and runs its course without benefit of man's assistance, to say nothing of his contaminating influence." [3] All human beings have: (a) natural needs which differ from those of other animals; (b) the ability to reason and to intellectually connect past, present, and future to attain knowledge; and (c) the ability to use free will to direct their actions. [4] Human beings have natural and unalienable rights, human rights, which rely on the above three propositions, the ethical right to attain a "good life" and the political right to create societies for the "common good." [5] Prudence, justice,

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[3] Wallace, W. A. (1985). Nature as animating: The soul in the human sciences. The Thomist, 49(4), p. 614.

[4] Adler, M. J. (1978). Aristotle for everybody. New York: Macmillan.

[5] Adler, M. J. (1971). The common sense of politics. New York: Holt, Rinehart & Winston, pp. 18-23.

moderation, and courage guide ethical and political thoughts and actions.

What human beings become, depends on the free choices the individuals make to develop their potentialities. These free choices are influenced by families and societies into which human beings are born. The knowledge acquired, understandings developed, and everything learned is a product of nurture which overlays the common nature of human beings. [6] The following definition of culture given by Lantz was accepted for this thesis: "The sum total of acquired values, beliefs, practices, laws, customs, traditions, artifacts, knowledge, language, and patterns of behavior possessed by a defined group." [7] Adler stated that the inequalities between sexes, races, and ethnic groups are due to nurture or culture and not nature. [8] If it is accepted that human beings have a common nature or essence, it follows that these inequalities could be eliminated.

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[6] Benedict, R. (1976). Continuities and discontinuities in cultural conditioning. In P. J. Brink (Ed.), Transcultural nursing: A book of readings (pp. 82-92). Englewood Cliffs, NJ: Prentice-Hill; Foster, G. M., & Anderson, B. G. (1978). Medical Anthropology. Toronto: Wiley & Sons; White, L. A. (1949). The science of culture. New York: Grove, p. vii.

[7] Lantz, J. M. (1989). Family culture and ethnicity. In P. J. Bomar (Ed.), Nurses and family health promotion: Concepts, assessment and interventions (pp. 47-54). Baltimore: Williams & Wilkins, p. 48.

[8] Adler, M. J. (1989). Human nature, nurture, and culture. The Aspen Institute Quarterly, 1(1), p. 103.

## Meaning of Nursing

Nursing came from the Latin word meaning "to nurture."

Adelaide Nutting and Lavinia Dock wrote:

> The art of nursing, at once the oldest of the occupations of women and the youngest branch of medical science, must have been co-existent with the first mother who performed for her little ones all those services which made it possible for them to live and thrive. [9]

In 1893 Florence Nightingale provided a broad definition of nursing:

> Both kinds of nursing are to put us in the best possible condition for nature to restore or to preserve health--to prevent or to cure disease or injury....Nursing proper is therefore to help the patient suffering from disease to live--just as health nursing is to keep or put the constitution of the healthy child or human being in such a state as to have no disease. [10]

Approximately one hundred years later the Alberta Association of Registered Nurses defined nursing as,

> A caring human service which recognizes the dignity, individuality, autonomy, and worth of each person. Nursing focuses on the maintenance of self-care activities to sustain life and health, on the recovery from disease and injury, and on the ability to cope with the effects of disease and injury of individuals, families, and groups. [11]

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[9] Nutting, M. A., & Dock, L. L. (1935). A history of nursing (Vol. 1). New York: Putnam's Sons.

[10] Nightingale, F. (1893). Sick nursing and health nursing. In National League of Nursing Education (Ed.), International congress of charities, correction and philanthropy (pp. 24-43). New York: McGraw Hill, p. 26.

[11] AARN. (1985). Position paper on nursing. Edmonton: Author.

For the purposes of this study it has been assumed that the meaning of nursing as a verb has remained quite stable through time.

## Purpose

The investigator's purpose in this historical study was to identify and analyze the impact of the AARN on the health care services and health policy of Alberta from 1916 to 1950. In pursuing this analysis it was essential to examine the AARN as an evolving profession. To provide a common understanding of the meaning of profession, the definition used in this study is given. Next, health was defined in order to help the reader better understand the meanings of health care services and health policy. Some ways in which a professional body could impact the health care services and health policy were then identified. As it is imperative in historical research to view the events being studied in the total historical context, some possible influences both internal and external to the AARN were discussed. Finally, the research approach used for this study is presented.

The definition of profession held for this thesis was that a profession is, "a cohesive and autonomous body of trained persons who perform work for the benefit of the public on the basis of applied scientific knowledge." [12] Stinson [13] suggested that the

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[12] Glaser, W. A. (1966). Nursing leadership and policy: Some cross-national comparisons. In F. Davis (Ed.), The nursing profession (pp. 1-59). New York: Wiley & Sons, p. 7.

criteria of a profession were: (a) autonomy meaning freedom from societal control, [14] (b) knowledge and skill meaning possession of special competence, [15] (c) service ideal meaning professional decisions based on the need of the client not the need of the professional, [16] and (d) a formal code of ethics meaning a code based on function and individual rights related to community norms. [17] Professionalization is the process of becoming professional or proceeding in a professional manner. [18] Wilensky identified a process of professionalization: (a) "start

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[13] Stinson, S. M. (1969). Deprofessionalization in nursing. Unpublished doctoral dissertation. Columbia University, New York, pp. 16-79.

[14] *Ibid.*, p. 35. A critical analysis of the literature regarding autonomy of a profession can be found on pages 46-57.

[15] *Ibid.*, p. 32-45, 156-167. Stinson wrote, "Any occupation wishing to exercise professional authority must find a technical basis for it, assert an exclusive jurisdiction, link both skill and jurisdiction to standards of training, and convince the public that its services are uniquely trustworthy." Adler identified five conditions necessary to making a branch of knowledge worthy of respect: (a) be a distinctive branch of knowledge, (b) be able to judge theories against an appropriate standard of truth, (c) be conducted as a public enterprise, (d) be relatively autonomous from other branches of knowledge, and (e) be able to identify questions of its own to answer (Adler, M. J. (1965). The conditions of philosophy. New York: Athenum).

[16] Stinson, 1969, pp. 57 to 62.

[17] *Ibid.*, pp. 62-73. According to Stinson written codes of ethics must be a balance between particularistic in nature based on function and universal in nature based on protection of individual rights which are related to community norms.

[18] Oxford English Dictionary. (1971). Oxford, UK: Author, p. 2316.

doing full time the thing that needs doing," (b) establishment of training schools, (c) formation of a professional association, (d) legal recognition to protect the "job territory", and (e) formal code of ethics. [19]

The meanings of health care services and health policy were based on the holistic concept of health used by the World Health Organization [WHO]. Health was viewed as "a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity." Continuing with the definition WHO stated that health, "is a fundamental human right...the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector." [20] A common understanding of the meaning of health among health professionals, governments, and the public is important as a guide for practice and policy, [21] therefore, the various definitions of health held by the AARN, other health

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[19] Wilensky, H. L. (1964). The professionalization of everyone? The American Journal of Sociology, 70(2), pp. 137-158.

[20] WHO. (1978). The Alma-Ata conference on primary health care. WHO Chronicle, 32, p. 428.

[21] Health and Welfare Canada. (1987). Active health report. Ottawa: Author; Keller, M. J. (1981). Toward a definition of health. Advances in Nursing Science, 3(1), pp. 43-52; Morse, J. M. (1987). The meaning of health in an inner city community. Nursing Papers, 19(2), pp. 27-41; Tripp-Reimer, T. (1984). Reconceptualizing the construct of health: Integrating emic and etic perspectives. Research in Nursing and Health, 7, pp. 101-109.

professions, governments, and the public throughout the period under study have been identified. Health care service is the work done to meet the health needs of an individual, family or group. [22] Health policy is the course of action adopted by a government related to health. [23] The legislation of the governments of Canada and Alberta which reflected this holistic concept of health was surveyed. Legislation reviewed focused on laws which: (a) protect society (i.e., licensing of health professional groups, food and drug quality controls, and environmental controls); (b) affect universality of health care (i.e., appropriations to health care programs, insurance programs, and changes in health care delivery systems); and (c) fund public and professional health education programs and health research.

A review of some of the nursing literature written over the last twenty years indicated three focuses for political activity by the nursing profession: (a) to increase and maintain control of the nursing profession, [24] (b) to help reform health care

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[22] The Concise Oxford Dictionary. (1964). Oxford, UK: Oxford University, p. 1159.

[23] *Ibid.*, p. 940.

[24] AARN. (1984). Nursing Profession Act. Edmonton: Author; Bachand, M. (1973). A discussion paper on the three major roles of provincial nurses' organizations. Ottawa: CNA, p. 5; Kopinak, J. K. (1990). Nursing in Canada: A profession in revolt. International Nursing Review, 37, pp. 312-314; MacPhail, J. (1988). The professional image impact and strategies for change. In J. Kerr and J. MacPhail (Eds.), Canadian issues and perspectives (pp. 47-58). Toronto: McGraw-Hill Ryerson.

services, [25] and (c) to advocate for health policy. [26]

Some social, political, cultural, and economic factors within and external to the AARN may have influenced its evolution as a profession and its ability to have an impact on health care services and health policy. Dynamics within the nursing profession that were considered in this historical study follow: (a) Nursing autonomy related to gender, culture, and work arrangements; [27] (b) Nursing leadership and unity in the AARN, as they are inextricably linked to one another and reflect the power

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[25] AARN. (1989). Position paper on health promotion. Edmonton: Author; AARN. (1989). Position paper on nursing in the home. Edmonton: Author; Rachlis, M., & Kushner, C. (1989). Second opinion. Toronto: Collins; Stanhope, M. (1979). Politics: The nurse and the health care consumer. New York: National League for Nursing [NLN].

[26] AARN. (1983). Position statement on nuclear disarmament (reviewed 1990). Edmonton: Author; AARN. (1986). Position statement on smoking and health. Edmonton: Author; AARN. (1989). Position statement on child day care. Edmonton: Author; AARN. (1989). Position statement on pornography. Edmonton: Author; Besharah, M. A. (1984). Canada health act. The Canadian Nurse, 80(4), pp. 8-9; Hegyvary, S. T., Duxbury, M. L., Hall, R. H., Kruger, J. C., Lindeman, C. A., Scott, J. M., & Scott, W. R. (1987). The evolution of nursing professional organizations. Kansas City, MO: American Academy of Nursing; Talbott, S. W., & Mason, D. J. (1988). Power and professional influence. In B. Kozier and G. Erb (Eds.), Concepts and issues (pp. 300-315). Menlo Park, CA: Addison-Wesley.

[27] Ashley, J. (1976). Hospitals, paternalism, and the role of the nurse. New York: Teachers College; Bergman, R. (1981). Accountability: Definition and dimensions. International Nursing Review, 28, pp. 53-59; Campbell, M. L. (1988). Accounting for care: A framework for analyzing change in Canadian nursing. In R. White (Ed.), Political issues in nursing: Past, present, and future (Vol.3) (pp. 45-70). London: Wiley & Sons; Chinn, P. L., & Wheeler, C. E. (1985). Feminism and nursing. Nursing Outlook, 33, 74-77; Melosh, B. (1982). The physician's hand: Work culture and conflict in American nursing. Philadelphia: Temple University; Styles, M. (1985). Accountable to whom? International Nursing Review, 32, pp. 73-75.

of the profession and of nurses as individuals; [28] and (c) Nursing education and socialization, as they are ways to ensure meeting two of the essential criteria of being a profession, skill and knowledge and service ideal. Socialization was viewed as an ongoing process in which a sense of belonging and ownership as well as participatory democracy are encouraged. [29]

Influences external to the AARN that may have affected the impact the AARN had on health care services and health policy in Alberta included: (a) the status of women in Alberta [30] and its relationship to the AARN, particularly the physician-nurse

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[28] Attridge, C., & Callahan, M. (1989). Women in women's work: Nurses, stress and power. Recent Advances in Nursing, 25, pp. 41-69; Baumgart, A. J. (1983). The conflicting demands of professionalism and unionism. International Nursing Review, 30, pp. 150-155; Douglass, L. M., & Bevis, E. O. (1979). Nursing management and leadership in action (3rd ed.). St Louis: Mosby.

[29] Brandt, M., & Craig, R. (1985). Follow the leader: A learning experience. Journal of Nursing Education, 24(4), pp. 139-142; George, T., & Larsen, J. (1988). The culture of nursing. In A. J. Baumgart & J. Larsen (Eds.), Canadian nursing faces the future: Development and change (pp. 63-74). St Louis: Mosby; Kalisch, B. J., & Kalisch, P. A. (1983). Anatomy of the image of the nurses: Dissonant an ideal models. In C. A. Williams (Ed.), Image-making in nursing (pp. 3-23). New York: American Nurses' Association; Yarling, R. R., & McElmurry, B. J. (1986). The moral foundation of nursing. Advances in Nursing Science, 8(2), pp. 63-73. Zanecchia, M. D. (1985). Experiential learning and changing leadership style. Journal of Nursing Education, 24, pp. 360-362.

[30] Boag, V. S. (1990). Writing about women. In J. Schultz (Ed.), Writing about Canada (pp. 175-199). Scarborough, Ont: Prentice Hall; Sanday, P. R. (1973). Toward a theory of the status of women. American Anthropologist, 75, pp. 1682-1700; Silverman, E. L. (1984). The last best West. Montreal: Eden; Vance, C., Talbott, S., McBride, A., & Mason, D. (1985). An uneasy alliance: Nursing and the women's movement. Nursing Outlook, 33, pp. 281-285.

relationship; [31] (b) the evolution of national and international professional associations of nursing and their influence on the AARN; [32] (c) the influence of science and technology on the development of the medical profession and hospitals and subsequently the influence of these changes on nursing and the AARN; and (d) the involvement of the public with health care services and health policy and its influence on the AARN. Leadership styles used by professionals in working with the client (individual, family, group) were analyzed according to beliefs held by professionals and the public as to dignity, worth, and equality of human beings [33] and the social and economic conditions at the time being investigated. [34]

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[31] Hoekelman, R. A. (1975). Nurse-physician relationship. American Journal of Nursing, 75, pp. 1150-1152; Nayak, M. T., & Nayak, V. T. (1984). Games that professionals play: The social psychology of physician-nurse interaction. Social Science and Medicine, 18, pp. 1063-1069; Ritter, T., Crulcich, M., & McEntegart, A. (1981). Nursing practice: An amalgam of dependence, independence, and interdependence. In J. C. McClosky & H. K. Grace (Eds.), Current issues in nursing (pp. 3-14). Boston: Blackwell Scientific Publications.

[32] Baumgart, A. J. (1985). Women's health: Directions for the 1980s. Health Care for Women International, 6, pp. 267-276; Morrow, H. (1986). Nurses, nursing and women. WHO Chronicle, 40, pp. 216-221; WHO. (1984). Women as providers of health care. International Nursing Review, 31, pp. 18-21.

[33] Barrow, N. (1988). Following the leaders in health for all. International Nursing Review, 35(5), pp. 137-142; Chaves, D. E., & LaRochelle, D. R. (1985). The universality of nursing: A comprehensive framework for practice. International Nursing Review, 32(1), pp. 10-13; Freire, P. (1970). Pedagogy of the oppressed (M. B. Ramos, Trans.). New York: Continuum; Heider, J. (1985). The Tao of leadership: Lao Tzu's Tao Te Ching adapted for a new age. Atlanta: Humanics; Maslow, A. H. (1968). Toward a psychology of being (2nd ed.). New York: Van Nostrand Reinhold; Maslow, A. H. (1987). Motivation and personality (rev. 3rd ed.). New York:

## Research Design

This study has an historical design. History is a science with its own kind of critical inquiry into a definite question. It is the study of past human events which are producers of and products of significant change, and which are consistent with all history and based on evidence. This change is not necessarily unidirectional, automatic, or inevitable. [35] History must be reinterpreted as perspective improves because of new research findings, improved methodologies, and increased time from events. Although interpretations may change, data remains unchanged. [36] History is scientific, humanistic, rational, and

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Harper & Row; Sovie, M. D. (1987). Exceptional executive leadership shapes nursing's future. Nursing Economics, 5(1), pp. 15-20.

[34] Anderson, A. B. , & Frideres, J. S. (1981). Ethnicity in Canada: Theoretical perspectives. Toronto: Butterworth; Armour, L. (1981). The idea of Canada and the crisis of community. Ottawa: Steel Rail; Bienvenue, R. M., & Goldstein, J. E. (Eds.). (1985). Ethnicity and ethnic relations in Canada (2nd ed.). Toronto: Butterworth; Driedger, L. (Ed.). (1978). The Canadian ethnic mosaic. Toronto: McClelland & Stewart; Friesen, G. (1987). The Canadian prairies. Toronto: University of Toronto [UofT]; Lower, A. R. M. (1952). Canada nation and neighbour. Toronto: Ryerson; Lower, A. R. M. (1958). Canadians in the making. Toronto: Longmans, Green and Co.; Mathews, R. (1988). Canadian identity. Ottawa: Steel Rail.

[35] Lynaugh, J., & Reverby, S. (1986). Thoughts on the nature of history. Nursing Research, 36(1), pp. 4, 69; Shafer, R. J. (Ed.). (1974). A guide to historical method. Georgetown, Ont: Irwin-Dorsey.

[36] Bloch, M. (1953). The historian's craft. New York: Knopf; Mandelbaum, M. (1967). The problem of historical knowledge. New York: Harper & Row.

self-revelatory. Learning what people have done in the past helps people develop knowledge of their own nature and abilities. [37]

Studying nursing history can help nurses develop an appreciation for past progress and an understanding of continuity in efforts which can help the profession to better understand its problems and can offer some direction for the future. [38] The object of this study was the AARN as a professional organization. Although this professional organization is made up of nurses as individuals and smaller groups with varying interests and ideas, it was assumed that from this plurality there also may emerge an interactional and interdependent whole. [39] According to Doheny,

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[37] Collingwood, R. G. (1956). The idea of history. New York: Oxford University; Duby, G. (1985). Ideologies in social history. In J. Le Goff & P. Nora (Eds.), Constructing the past (pp. 151-165). New York: Cambridge University; Meyerhoff, H. (Ed.) (1959). The philosophy of history in our time. Garden City, NY: Doubleday Anchor; Pirenne, H. (1959). What are historians trying to do? In H. Meyerhoff (Ed.), The philosophy of history in our time (pp. 87-98). Garden City, NY: Doubleday Anchor; Scriven, M. (1966). Causes, connections, and conditions in history. In W. H. Dray (Ed.), Philosophical analysis and history (pp. 238-264). New York: Harper & Row.

[38] Ashley, J. (1978). Foundations for scholarship: Historical research in nursing. Advances in Nursing Science, 1(1), pp. 25-36; Church, O. M. (1987). Historiography in nursing research. Western Journal of Nursing Research, 9(2), pp. 275-279; Davies, C. (Ed.). (1980). Rewriting nursing history. Totowa, NJ: Barnes & Noble; Jennings, B. M. (1987). Historical research in nursing: An alternate mode of inquiry. In S. R. Gortner (Ed.), Nursing Science Methods (pp. 51-57). San Francisco: University of California; Newton, M. E. (1965). The case for historical research. Nursing Research, 14(1), pp. 20-26.

[39] Berkhofer, R. F. (1969). A behavioral approach to historical analysis. New York: Macmillan; Schultz, P. R. (1987), When client means more than one: Extending the foundational concept of person. Advances in Nursing Science, 10(1), pp. 71-86.

Cook, and Stopper, "In the process of professionalization a group consciousness develops." [40]

## Method

An holistic view of the development of the AARN required a synthesis of social, psychological, political, cultural, and economic dimensions of life. [41] An historical fact has been defined by Mandelbaum as being, "the occurrence of a specific event at a specific time and place." [42] Historical method requires the interpretation, not merely the collection of facts. [43] To avoid undue bias, the historian must be always aware that historical interpretation is inextricably tied to the total historical context

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[40] Doheny, M., Cook, C., & Stopper, M. (1987). The discipline of nursing (2nd ed.). Norwalk, CT: Appleton & Lange, p. 101.

[41] Barraclough, G. (1957). History in a changing world. Oxford: Blackwell; Mink, L. O. (1966). The autonomy of historical understanding. In W. H. Dray (Ed.), Philosophical analysis and history (pp. 160 -192). New York: Harper & Row; Phenix, P. (1964). Realms of meaning. New York: McGraw-Hill; Toynbee, A. J. (1959). The unit of historical study. In H. Meyerhoff (Ed.), The philosophy of history in our time (pp. 99-119). Garden City, NY: Doubleday Books; Ward, P. L. (1971). Elements of historical thinking. Richmond, VA: American Historical Association.

[42] Mandelbaum, M. (1967). The problem of historical knowledge. New York: Harper & Row, p. 213.

[43] Barazun, J., & Graff, H. F. (1970). The modern researcher. New York: Harcourt, Brace & World; Finley, M. I. (1963). Generalizations in ancient history. In L. Gottschalk (Ed.), Generalization in the writing of history (pp. 19-35). Chicago: The University of Chicago; Lovejoy, A. (1959). Present standpoints and past history. In H. Meyerhoff (Ed.), The philosophy of history in our time (pp. 87-98). Garden City, NY: Doubleday Anchor; Walsh, W. H. (1959). Can history be objective? In H. Meyerhoff (Ed.), The philosophy of history in our time (pp. 216-224). Garden City, NY: Doubleday Anchor; Winks, R. W. (Ed.). (1968). The historian as detective. New York: Harper & Row.

and to the values held by the historian, primary sources, and secondary sources.

Historical material is usually organized geographically, topically, and/or chronologically. As the object of this study was the AARN, the focus geographically was narrowed particularly to a discussion of Alberta. However as Alberta is not isolated from national and international affairs, it was occasionally necessary to consider the effects of various relevant outside influences to provide a better understanding. The time period studied primarily involved events occurring from 1916, when the Alberta Association of Graduate Nurses was incorporated, to 1950. This provided more than the twenty year perspective that was recommended by Christy [44] and Tuchman. [45]

The primary sources examined to identify and analyze influences within the AARN included the: (a) official executive and general council minutes, (b) official briefs to the government and other organizations, and (c) official statements and position papers. Secondary sources included the AARN newsletter and histories written about and by Alberta nurses.

Influences external to the AARN were studied by exploring a number of primary sources such as: (a) Albertan legislation on

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[44] Christy, T. E. (1983). Dr. Christy's methodology of historical research. [Videocassette No. CM 511 A, B]. Iowa City: University of Iowa.

[45] Tuchman, B. W. (1981). Practicing history. New York: Knopf.

health and social policy from 1905-1950, (b) Canadian legislation from 1867 to 1950, and (c) official policies and statements by the CNA and ICN from the formation of these professional associations to 1950. Secondary sources such as the journals of the following professional associations were also examined from the first publications until 1950: Canadian Nurses Association [CNA], International Council of Nurses [ICN], American Nurses Association [ANA], Canadian Medical Association [CMA], Canadian Public Health Association [CPHA], Alberta Public Health Association [APHA], and Alberta Medical Association [AMA]. Histories written about and by Canadian nurses and Alberta doctors were discussed in the investigation to provide more background information.

Footnotes were used to provide the reader with the sources of the data, to include anecdotal material, and to document any confusion among sources with regard to statements made by the investigator.

## External and Internal Criticism

According to Christy [46] and Nevins [47] history attempts to determine the truth of an event. To establish the truth two criteria must be met, external and internal criticism. Carr

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[46] Christy, T. E. (1975). The methodology of historical research: A brief introduction. Nursing Research, 24(3), pp. 189-192.

[47] Nevins, A. (1962). The gateway to history. Garden City, NY: Anchor Doubleday.

alleged, "facts of history never come to us 'pure'...they are always refracted through the mind of the recorder. It follows that...our first concern would be not with the facts which it contains but with the historian who wrote it." [48] For external criticism, it was essential that an approximate date, some identification of the author, and the place of origin of the document be included in the study. Primary sources were used as much as possible while secondary sources provided setting details, unavailable quotations, and possible interpretations.

Internal criticism or credibility has been defined as that which probably happened based on critical examination of the best available evidence from the best available sources. Four tests suggested by Gottschalk [49] were used to determine credibility: (a) could the primary witness tell the truth, (b) was the primary witness willing to tell the truth, (c) was the primary witness accurately reported, and (d) was there independent corroboration. Truth was ascertained as probable by the investigator by using common sense based on the knowledge of these events today, and taking into consideration the knowledge available at the time of the event. Any fact thought to be a forgery was examined to

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[48] Carr, E. H. (1964). What is history? New York: Knopf, p. 24.

[49] Gottschalk, L. (1950). Understanding history: A primer of historical method. New York: Knopf.

discover the underlying motivations, and silences within the data were identified and analyzed to help provide the complete picture.

Christy [50] called a fact a piece of evidence that has two independent primary sources or one primary source and one credible corroborative secondary source. A primary source with corroboration can be referred to as probability, while a primary source which passes critical analysis but has no corroboration, or two primary sources that disagree to a limited extent, are considered possibility.

## Data Analysis

Historical events, being unique and non-recurrent, cannot be due to single causes, but rather are said to have multiple causes, sufficient conditions, or significant prerequisites. [51] Most historians denied the possibility to predict and to control the future through discovery of general laws of cause and effect, however, identification of probable necessary conditions leading to events in the past would seem to help provide explanations and generalizations that could be used to guide the future. [52]

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[50] Christy, T. E. (1975). The methodology of historical research: A brief introduction. Nursing Research, 24(3), pp. 189-192.

[51] Nagel, E. (1959). The logic of historical analysis. In H. Meyerhoff (Ed.), The philosophy of history in our time (pp. 203-215). Garden City, NY: Doubleday Anchor; Oakeshott, M. (1966). Historical continuity and causal analysis. In W. H. Dray (Ed.), Philosophical analysis and history (pp. 193-212). New York: Harper & Row; White, M. (1965). Foundations of historical knowledge. New York: Harper & Row.

[52] Carr, E. H. (1964). What is history? New York: Knopf;

## Chapter II

### Setting the Stage for the Establishment of the AARN

The years 1867 to 1918 represented the formative years of Canada and Alberta. During this time health and social policy set the framework from which nursing in Canada continued to evolve. In the first two decades of the twentieth century, the Christian religions played an extensive role in Canada, particularly in the West, in education, in immigration, in politics, and in helping to create a unity among groups of people. [53] Lower suggested a link between Christian sects and support of socialization in Canada:

> At every critical juncture in our national life, when we have been faced with a choice between individualism and socialization, we have chosen socialization....These triumphs of socialization have not denied outlet to individual energies. Within the general planned pattern, individualism has made its own large contribution to Canadian life....The Canadian people have, in fact, virtually without knowing it, worked out a way of life unique in the modern world; in their

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Daniels, R. V. (1966). Studying history: How and why. Englewood Cliffs, NJ: Prentice-Hall; Dray, W. (1957). Laws and explanation in history. Toronto: Oxford University; Gottschalk, L. (1963). Generalization in the writing of history. Chicago: University of Chicago.

[53] Lower explained, "The Methodists became a people with a deep social conscience, the leaders in the movements of social progress. Though they might not then realize it, that road led straight to politics, and if they were to be true to their faith, to the left wing of politics" (Lower, A. R. M. (1977). Colony to nation. Toronto: McClelland & Stewart, p. 167). Owran wrote, "The North West, through necessity and opportunity, would encourage religious unity....The sense of religious mission was an integral part of the more general desire to establish a moral and stable society in the best traditions of the British Empire" (Owram, D. (1980). Promise of Eden. Toronto: UofT, pp. 147-148).

> own practical, unvocal way, they have found a way of combining collectivism, and individualism, the united effort of the community and personal efforts of citizens. [54]

The initial legislation passed by government provided insight into the priorities of the people of the time.

## Health Care Services and Health Policy

Canada's federal form of government was created with the intention that the major legislative powers would be held by the central government rather than the provinces. [55] Significantly, health care was primarily designated a provincial responsibility. The BNA Act named only the "Quarantine and the Establishment and Maintenance of Marine Hospitals" [56] under the duties of the Parliament of Canada, while the provincial legislatures were given exclusive powers over, "the Establishment, Maintenance, and Management of Hospitals, Asylums, Charities, and Eleemosynary Institutions in and for the Province." [57]

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[54] Heick, W. H. (Ed.). (1975). Arthur Lower and the making of Canadian nationalism. Vancouver: University of British Columbia [UBC], pp. 115-116.

[55] Creighton, D. (1970). Canada's first century (1867-1967). Toronto: Macmillan, p. 11.

[56] Dominion of Canada. (1867). Statutes of Canada. Ottawa: Author, p. 19.

[57] *Ibid.*, p. 21.

The Quarantine and Health Act [58] amended in 1872 included some public health regulations related to "epidemic, endemic, contagious and infectious disease" [59] in all parts of Canada. That this was one of the first and primary concerns about health by the new Federal government was not surprising. Epidemics of measles (1819-1820), diphtheria (1836) and smallpox (1837, 1869) caused many deaths. Though everyone was affected, the Métis and Indian populations of the prairies were particularly devastated. [60]

The fear of epidemics [61] stimulated Alberta's Premier Rutherford to identify in the inaugural speech from the throne the

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[58] Dominion of Canada. (1868). Statutes of Canada. Ottawa: Author, pp. 201-206.

[59] Dominion of Canada. (1872). Statutes of Canada. Ottawa: Author, pp. 110-114.

[60] MacGregor, J. B. (1981). A history of Alberta. Edmonton: Hurtig, p. 63. MacGregor noted that during the 1837 smallpox epidemic six thousand of nine thousand Indians of the Blackfoot Confederacy died. Again in, "the winter of 1864-65, scarlet fever and measles...had been on the rampage, and, in what are now the provinces of Alberta and Saskatchewan, killed about twelve hundred of the native population" (p. 85). The Indian population in Alberta increased by 46 people, from 6,435 in 1901 to 6,481 in 1906 (Government of Canada. (1907). Census of population and agriculture of the Northwest provinces (1906). Ottawa: Davison, p. xxi).

[61] In 1892 concern about a possible smallpox outbreak moved Frank Oliver, as editor and owner of the Edmonton Bulletin , to publish the following editorial:

> It is our duty in our own interests and in the interests of the whole country to see that this disease does not get a foothold here, or if it does to see that the measures usually taken in such cases are taken promptly and effectually....Terrible although the small-pox is, it is a strictly preventable disease....This is a case in which it is the plain duty of the town council, the local government and the Dominion

formulation of a public health law as one of his government's priorities: "The present law governing public health and sanitation having been found by practical experience to be unworkable and...inadequate to meet the growing necessities of the Province." [62] This act was passed March 15, 1907. [63]

Other health issues were identified by Dr. Wood in 1880: (a) use and abuse of alcohol; (b) "intemperate employment of food"; (c) poor public hygiene (sewage disposal, pollution) and personal hygiene ("proper dress, exercise, correct amount of sleep, bathing, quantity and quality of breathing air, the cleanliness of the house and its temperature"); and (d) poor

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government to co-operate to absolutely prevent this disease getting a foothold in this part of the country, going even to the extreme of quarantining railway passengers and disinfecting imported goods. (Staff. (1892, July 21). Danger. Edmonton Bulletin, p. 2) On July 23rd, 1892, two days after Oliver's editorial was published, the Edmonton town council met and passed a by-law establishing a board of health with a wide range of powers to ensure the protection of Edmontonians.

[62] Staff. (1906, March 15). Edmonton Bulletin, p. 7.

[63] Government of Alberta. (1907). Statutes of Alberta. Edmonton: Author, pp. 234-263. A provincial board of health lead by a physician was responsible for directing local boards of health. General powers included, "all such matters, acts and things as may be necessary for the protection of the public health and for ensuring the full and complete enforcement of every provision of this Act" (p. 239). The board was further mandated to "make public distribution of such sanitary literature and of special practical information relating to the spread of contagious and infectious diseases" (p. 239), the first legislative step in the area of health education. On the same day the vital statistics law was passed indicating the government's recognition of the importance of statistics to future health care planning. Also in 1907 a provincial laboratory was established by Dr. G. V. Revell (Jamieson, H. C. (1947). Early medicine in Alberta. Edmonton: Douglas, p. 72; Schartner, A. (1982). Health units of Alberta. Edmonton: Co-op, p. 22).

lifestyle choices, "In this age of steam and electricity not to kill ourselves in the race for wealth, position or power." Dr. Wood stated that physicians should be, "a great social power for good" helping "to bring the human race to a state of perfection." [64] Some physicians recognized this leadership role and began lobbying the Canadian government to set up a Dominion Board of Health. They predicted that, "One of the chief aims of legislation...would be the conservation of the health and preservation of the lives of the people, for the possession of the health and increase of inhabitants must be regarded as the equivalent of capital." [65]

Health policy developed in direct response to the health issues and health threats of this period in history, and health services were directly responsive to the perceived needs of the community. For example, the 1869 smallpox epidemic provided the impetus for a number of initiatives for improving health care:

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[64] Wood, C. A. (1880). The social duties of the medical profession. The Canada Medical Record, 8, pp. 253-257.

[65] Campbell, F. W. (Ed.). (1880). Board of health. The Canada Medical Record, 8, pp. 108-110. Three members of the Alberta Liberal government in 1911 carried the title, doctor: (a) Dr. W. A. Campbell a medical doctor represented Ponoka from 1908 to 1917 (Jamieson, H. C. (1947). Early medicine in Alberta. Edmonton: Douglas, pp. 119, 188); (b) Dr. J. H. Rivers a medical doctor represented Lethbridge (Jamieson, H. C. (1947). Early medicine in Alberta. Edmonton: Douglas, pp. 137, 188); and (c) Dr. Warnock of Pincher Creek may not have been a medical doctor as he was not listed as being registered in Alberta between 1906-1911 (Jamieson, H. C. (1947). Early medicine in Alberta. Edmonton: Douglas, pp. 141-198).

(a) the establishment of the first hospital in central Alberta by the Grey Nuns when they set up a patient ward at the St. Albert mission; [66] (b) the initiation of the first board of health in the Alberta region of the Northwest Territories in 1871; [67] (c) the successful experiment in vaccines [68] by Reverend James Nesbitt of Prince Albert and Isaac Cowie at Fort Qu'Appelle; and (d) the success of quarantine and embargoes in controlling spread of diseases. [69] The Grey Nuns, the first providers of health care services, established the Edmonton General Hospital in Alberta in 1895: "This is a general hospital, superintended and run by the

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[66] Paul, P., & Kerr, J. R. (1990). Called to care: The mission of the Grey Nuns in Alberta. Proceedings of the Third Annual Conference of the Canadian Association for the History of Nursing (pp. 64-72). Calgary, Alberta: Canadian Association for the History of Nursing [CAHN], p. 69.

[67] Cashman, T. (1966). Heritage of service. Edmonton: AARN, p. 15; Schartner, A. (1982). Health units of Alberta. Edmonton: Co-Op, p. 17. Rather than continue to use the various forms of this place name that have been used throughout Canada's history, the present day form of Northwest Territories will be used consistently.

[68] Bridgwater, W. (Ed.). (1953). The Columbia Viking Desk Encyclopedia (Vol 2). New York: Viking, p. 627. Edward Jenner successfully used cowpox vaccine to protect James Phipps against smallpox in 1796.

[69] To curtail the smallpox epidemic, an embargo was placed on the shipment of buffalo robes, leather and furs (Cashman, T. (1966). Heritage of service. Edmonton: AARN, p. 15); "Reverend George McDougall...said 'Scatter them, scatter them. Do all you can to scatter the people for that is the only hope of saving them'" (Schartner, A. (1982). Health units of Alberta. Edmonton: Co-Op, p. 17).

sisters of charity, and all have free access without distinction of creed, nationality." [70]

Due to the expanse of territory and sparse population of Canada and Alberta many people had no access to medical care by physicians. [71] In response to this need in 1897 Lady Aberdeen, wife of the Governor-General of Canada, founded the Victorian Order of Nurses [VON]. [72] The VON provided services in remote areas and cared for the sick poor in urban areas. [73] As early as 1907 the Alberta government began to subsidize curative hospital care. [74] The Edmonton Bulletin on March 13 quoted Premier

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[70] Staff. (1896, January 30). Edmonton General Hospital. Edmonton Bulletin. Sister Mary Xavier from St. Boniface, was in charge of the hospital which opened for patients on February 5, 1896.

[71] Jamieson, H. C. (1947). Early medicine in Alberta. Edmonton: Douglas, p. 65. The first doctor, employee of the Hudson's Bay Company, Dr. W. M. MacKay, arrived in Alberta in 1864. The first lay nurse arrived to practice in Alberta in 1886. Mary Newton, graduate of Queen Charlotte's Maternity Hospital London, came to live with her brother, an Anglican missionary (Cashman, T. (1966). Heritage of service. Edmonton: AARN, p. 19).

[72] Lady Aberdeen founded the National Council of Women of Canada [NCWC] (Boag, V. S. (1979). The roots of modern Canadian feminism. In B. Hodgins & R. Page (Eds.), Canadian history since confederation (pp. 398-408). Georgetown, Ont: Irwin-Dorsey, p. 402). The NCWC was instrumental in founding the VON (CNA. (1968). The leaf and the lamp. Ottawa: Author; Gibbon, J. M., & Mathewson, M. S. (1947). Three centuries of Canadian nursing. Toronto: Macmillan).

[73] Gibbon, J. M., & Mathewson, M. S. (1947). Three centuries of Canadian nursing. Toronto: Macmillan, p. 268. Two nurses and a maid were to run cottage hospitals that could accomodate six to ten patients.

[74] Government of Alberta. (1907). Statutes of Alberta. Edmonton: Author, pp. 50-51.

Rutherford following the proposal of an increase in the Hospitals and Charities [75] budget: "We feel that in the early history of our province it is desirable that the hospital work would be encouraged so that it will not be burdensome upon the people of the province."

Initiatives to enhance health care services could not meet the needs of a population that from 1906 to 1911 had increased 413% to 374,295 in Alberta, as compared to a 34% increase in the total population of Canada which was reported as being 7,206,643. [76] According to the Alberta census of 1911, there were 369 physicians and surgeons and only 361 nurses. This meant there was one doctor for every 1,014 people and one nurse for every 1,037 people in Alberta, however it should be assumed that the majority of these health professionals worked in one of Calgary's two or one of Edmonton's three hospitals. [77]

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[75] It is not at all surprising that hospitals would have been linked in a government portfolio with charities because up to this time in history hospitals were established and operated as charitable institutions most often by religious groups as part of their missionary work.

[76] Dominion of Canada. (1925). Sixth census of Canada 1921 (Vol. 2). Ottawa: Acland, pp. 7, 15.

[77] Dominion of Canada. (1915). Fifth census of Canada, 1911: Occupations of the people (Volume VI). Ottawa: Author, pp. 68-69. The Edmonton Journal of January 31, 1912 printed a plea from the MLA for Lac Ste. Anne, Peter Gunn, for medical help for the North as there was no doctor in the whole of the Pembina.

Throughout this time period the meaning of health held by the population of Canada primarily seemed to be the absence of disease, illness, and disability. In the harsh climate of a new country like Canada, with few people in a position to provide health and social assistance, the chances of survival would have been very limited for any person who was not young, strong, and healthy.

## Status of Women

Women in Alberta and Canada received the franchise with less of a struggle and before women in many other countries, however the journey toward gender equality in many aspects of political and social life was not as easy as the following quote by Lower might suggest: [78]

> Europeans have always been surprised...at the freedom between the sexes in North America....Freedom is simply a reflection of pioneer simplicity and equality....In 1900, Canada, a country where men outnumbered women, had not remotely approached the stage of sophisticated relationship between the sexes. Pioneer democracy expressed itself not in sophistication but in a greater degree of legal equality than in older countries....In Canada no such 'feminist

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[78] The provincial vote in Alberta was extended to all females exclusive of Treaty Indians on April 19, 1916 (Government of Alberta. (1916). An act to provide for equal suffrage. Statutes of Alberta. Edmonton: Author, Chapter 5, pp. 56-57). On May 24, 1918 women except for Treaty Indians received the vote federally under the same conditions as men (Dominion of Canada. (1918). An act to confer the electoral franchise upon women. Statutes of Canada. Ottawa: Author, Chapter 20, pp. 69-70). Women in the USA received the vote in 1920 and in Great Britain in 1928 (Lower, A. R. M. (1958). Canadians in the making. Toronto: Longmans, Green).

> movement' as later developed in England could get under way, simply because there was not the requisite resistance to it. [79]

Even though some men were more enlightened than others in recognizing gender equality, [80] there were a number of incidences found in the literature that would suggest many viewed women as less than equal. Society expected upper class women to find worthy charitable causes to occupy their free time. A group of women founded and managed for seventeen years the Toronto Hospital for Children, however when the hospital expanded and required more complex management a male board of trustees was appointed. [81] Society informally classified professions as being more suitable for one of the genders, for instance nursing was seen as a female profession while medicine was seen as a male profession. It was not until 1880 that Emily Howard Stowe, the

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[79] Lower, A. R. M. (1977). Colony to nation. Toronto: McClelland & Stewart, p. 416.

[80] The editor of the Edmonton Bulletin wrote,

> Casting old prejudices aside there does not seem to be any good and sufficient reason why a woman having the same or similar intellectual and property qualifications as a man should not be allowed a voice in the affairs of the nation. It is not an article of belief with us...that woman is an inferior animal. She is an equal in all but the right to vote.

(Staff. (1883, June 2). The elections. Edmonton Bulletin, p. 2).

[81] Gibbon, J. M., & Mathewson, M. S. (1947). Three centuries of Canadian nursing. Toronto: Macmillan, pp. 418-419; Young, J. (1990, June). Elizabeth McMaster: Hospital pioneer and nurse. Proceedings of the Third Annual Conference of the Canadian Association for the History of Nursing (1875-1892). (p. 31). Calgary: CAHN. The hospital was founded in 1875 by Elizabeth McMaster.

first Canadian woman to practice medicine in Canada, was finally admitted to the Ontario College of Physicians and Surgeons. [82] According to Boag, the NCWC, the most powerful women's association in Canada from 1893 to 1929 did not adopt a woman suffrage platform until 1910. [83] In 1905 Laurier demonstrated gender bias in his speech on equality when he referred only to "gentlemen", "sir", and "he":

> Gentlemen...it is necessary that we should have the hearty co-operation of all the people, of all the citizens of Alberta....Let me say...gentlemen, to those newly our fellow countrymen, that...we want to share with them our land, our laws, our civilization. Let them be British subjects, let them take their share in the life of this country, whether it be municipal, provincial or national. Let them be electors as well as citizens. [84]

John T. Moore, [85] Member of the Legislative Assembly [MLA] for Red Deer, commented on the non-sectarian and co-education plan

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[82] Marsh, J. H. (Ed.). (1985). The Canadian encyclopedia (Vol. 3). Edmonton: Hurtig, p. 1762. After setting up an unlicensed practice in Toronto in 1867, she organized the Women's Medical College in 1883, and founded the first suffrage group in Canada. In 1889 she became the founder and first president of the Dominion Women's Enfranchisement Association. The Sex Disqualification Act passed in 1930 removed any disqualification by sex or marital status (Government of Alberta. (1942). Revised statutes of Alberta. Edmonton: Alberta. p. 4215).

[83] Boag, V. S. (1979). The roots of modern Canadian feminism. In B. Hodgins & R. Page (Eds.), Canadian history since confederation (pp. 398-408). Georgetown, Ont: Irwin-Dorsey, p. 402.

[84] Staff. (1905, September 5). Laurier's speech. Edmonton Bulletin, p. 7.

[85] Staff. (1908, January 17). Composition of the legislature. Edmonton Bulletin. Mr. Moore designated his occupation as capitalist. On

for the University of Alberta: "Sweet girl graduates...may there be many....'The hand that rocks the cradle rules the world', and I hope that the hand will not rock the cradle any the less deftly on account of having received a university training."

Petitions of the Equal Franchise League and the Local Council of Women of Calgary were presented by Mr. Sifton on October 13, 1914. The forty-four societies and 3000 individuals requested amendment of the Election Act of 1909 "by striking out the word 'male' before the word 'person'." No evidence of further discussion or action was recorded in the legislature. [86] Attempts to pass laws to protect the property rights of women began early in Alberta's history. Although many MLA's questioned the necessity for this law, the Dower Act written by Emily Murphy and presented by R. B. Bennett finally passed in 1911. [87]

The status of women was inadvertently affected by the war when women were actively recruited to fill work positions

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September 4, 1908 the University of Alberta (UofA) began classes in Strathcona's Queen Alexandra School. In 1913, five women graduated as part of the UofA's first class of eighteen students (MacGregor, J. B. (1981). A history of Alberta. Edmonton: Hurtig).

[86] Cleverdon, C. L. (1950). The woman suffrage movement in Canada. Toronto: UofT; Government of Alberta. (1914). Journals of the Legislative Assembly. Edmonton: Richards, pp. 22-23.

[87] Lazarus, M. (1983). Six women who dared. Toronto: CPA Publishers.

previously held by men. [88] By performing new roles and taking on new responsibilities many women gained confidence in their abilities to learn and to perform new skills. The war often has been credited as one of the catalysts toward equal suffrage, however many of the other freedoms gained by women were lost with the return to peace time "normality." Nurses also gained confidence in their abilities to work independently and to control their profession. On February 7, 1918, for the first time in the British Empire, women occupied seats in a legislature: Louisa C. McKinney of Claresholm and Roberta MacAdams, [89] a nurse and representative of the soldiers overseas, were elected to the Alberta government.

## Nursing Profession

In 1893, Florence Nightingale announced, "A new art and a new science has been created...within the last forty years....a new profession--so they say; we say, calling." [90] She cautioned

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[88] "This is the women's year, all occupations are open to them and they may be found filling many unwonted positions. In England educated women are acting as accountants, draughtsmen, analytical chemists, supervisors in munition works, and agriculturists" ( Scovil, E. R. (1916). Narratives from the war. The American Journal of Nursing, 16, p. 513).

[89] Lavinia Dock in 1917 in an article titled, "Canada Ahead Again" (The American Journal of Nursing, 18, p. 228) wrote that the election of Miss Roberta MacAdams was "the most modern thing that has happened to the nursing profession anywhere....Even Florence Nightingale never had so unique a distinction as this....Suffragists everywhere, as well as nurses, are rejoicing."

[90] Nightingale, F. (1893). Sick nursing and health nursing. In National League of Nursing Education (Ed.), International congress of

against making nursing a profession, "What is it to feel a calling for anything? Is it not to do our work in it to satisfy the high idea of what is the right, the best, and not because we shall be found out if we don't do it?" [91] A "calling" focused almost exclusively on one component of a profession that of service ideal because it referred to a response to God's request for service to others. Isabel Robb emphasized the responsibility of nurses for their profession:

> A direct call from God to a consecrated service, would rather suggest,...a sisterhood with its religious restrictions; and surely profession means all that vocation does and more....The term implies more responsibility, more serious duty, a higher skill and an employment needing an education more thorough than that required in some other vocations of life. [92]

Isabel Stewart described the responsibility of a profession to society in general, "there is nothing sacred about any institution or profession....Survival of the nursing profession and its development in the future will depend therefore on the way in which it meets the changing needs of society." [93]

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charities, correction and philanthropy (pp. 24-43). New York: McGraw Hill, p. 24.

[91] *Ibid.*, p. 32.

[92] Robb, I. H. (1900). Nursing ethics. Cleveland: Koeckert, p. 33.

[93] Stewart, I. M. (1936). The nurse and changing social needs. Paper presented at the commencement of the New York Hospital Nursing School, p. 4.

"The World's Fair Congress on Hospitals, Dispensaries and Nursing in 1893 marks the 'coming out' of nursing as a profession (in the making)." [94] With the leadership of Isabel Robb this congress led to the formation of the American Society of Superintendents of Training Schools for Nurses in 1894. [95] Three years later, she became the first president of another organization, this time of nursing practitioners, the Nursing Associated Alumnae of the United States and Canada. [96]

One of the catalysts for forming a Canadian association was the ability to then become an official member of the ICN. Mrs. Bedford Fenwick (1857-1947), former matron of St. Bartholomew's in England, had helped to establish the ICN on July 1, 1899. [97] Canada was initially a provisional member with M. A. Snively as treasurer. [98] M. A. Snively spearheaded a movement by

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[94] Stewart, I. M. (1949). Introduction. In National League of Nursing Education (Ed.), International Congress of Charities, Correction, and Philanthropy (pp. xv-xix). New York: McGraw Hill. Reissue of part 3, Nursing of the sick, written in 1893. Isabel Robb chaired the committee that arranged this meeting.

[95] It was renamed the National League of Nursing Education in 1912 and in 1952 the National League of Nursing [NLN].

[96] Nutting, A. (1910). Isabel Hampton Robb: Her work in organization and education. American Journal of Nursing, 10, pp. 19-25.

[97] Dock, L. L. (1900). The International Council of Nurses. The American Journal of Nursing, 1(2), p. 115.

[98] The objects of the council were to improve international unity of nurses through better communication concerning patient welfare and nursing professionalism.

the Canadian Society of Superintendents of Training Schools [99] which resulted in the successful creation of a national nursing association, The Provisional Organization of the Canadian National Association of Trained Nurses [CNATN] on October 8, 1908. She stated,

> Let us all remember that privilege means responsibility: that a better century does not mean that it should minister unto us, but we to it; and also, that we can only be worthy of the great inheritance which has been bequeathed to us as we use our larger opportunities to make our country and the world better, and brighter, and purer with each succeeding year. [100]

Autonomy

From its inception the CNATN recognized the need to pass registration laws as an essential first step toward autonomy of a profession. In her presidential address, Mary Agnes Snively encouraged:

> With unity among nurses, and a thorough understanding on their part of all that registration involves, together with the sympathy and co-operation of an enlightened public, the

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[99] Mary Agnes Snively was the first president of this organization when it was founded in 1907. In 1917 it changed its name to the Canadian Association of Nursing Education [CANE] and in 1924 the need to provide a united national organization led to the merger of this association with the CNATN (CNA. (1968). The leaf and the lamp. Ottawa: Author, pp. 83-85).

[100] CNA. (1926?). A brief history of the Canadian Nurses Association. Winnipeg: Author, p. 22.

> cause of registration cannot fail of accomplishment in the near future in Canada. [101]

By the CNATN third general meeting in Kitchener on May 21, 1913 the committee on Dominion Registration suggested that:

> It is of vital importance to the profession that there be uniformity of standards, that the training and registering of nurses be the same, fundamentally, in all parts of Canada. We would suggest that there be a Dominion Registration Committee, to draw up a model bill....The committee, however, urges nurses to continue moulding public opinion and agitating for really educative courses for student nurses and for high standards. [102]

Skill and Knowledge

In 1874 the first training school for nurses was organized by Dr. Theophilus Mack at the General and Marine Hospital at St. Catharines, Ontario. [103] By 1909 Canada had approximately seventy training schools seven of which were in Alberta. [104]

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[101] CNA. (1926?). A brief history of the Canadian Nurses Association. Winnipeg: Author, p. 22. Edmonton and Calgary Graduate Nurses Associations as affiliates of the CNATN sent delegates to the first general meeting in Niagara Falls on May 22, 1911. It was recommended at this first meeting that a library and archives be established.

[102] CNA. (1926?). A brief history of the Canadian Nurses Association. Winnipeg: Author, p. 29

[103] CNA. (1968). The leaf and the lamp. Ottawa: Author, p. 32; Gibbon, J. M., & Mathewson, M. S. (1947). Three centuries of Canadian nursing. Toronto: Macmillan, p. 144. Gibbon and Mathewson declared, "Dr. Mack was convinced that the prejudice held by many sick people against going into public hospitals could best be overcome by building up a profession of trained lay nurses."

[104] CNA. (1968). The leaf and the lamp. Ottawa: Author; Cashman, T. (1966). Heritage of service. Edmonton: AARN, pp. 42-65.

Nursing education in Canada was initially based on the apprenticeship model. Nora Livingston established a school of nursing at the Montreal General Hospital in 1890 which initiated the first preliminary class in nursing with Flora Madeline Shaw as instructor. This event led to the first three year nursing course in America. [105] In 1905, the Toronto General Hospital nursing alumnae association published The Canadian Nurse with Dr. Helen MacMurchy as part-time editor. [106] In 1916, The Canadian Nurse with 1,800 subscribers was bought by the CNATN for $2,000.00 and Helen Randall was appointed editor. [107] The CNATN realized early in its history the importance of standardizing and improving nursing education and having The Canadian Nurse as an organ to unite and educate nurses.

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[105] MacDermot, H. E. (1940). History of the school of nursing of the Montreal General Hospital. Montreal: Alumnae Association, pp. 36-37, 51, 54; The History of Nursing Society. (1929). Pioneers of nursing in Canada. Montreal: Gazette, pp. 2, 25.

[106] A doctor was appointed in an effort to avoid the medical community's criticism that this was a move by nurses toward autonomy (CNA: A pictorial record. The Canadian Nurse, 79(9), p. 41). One of the stimulants to beginning The Canadian Nurse may have been provided by a request for a nursing magazine by the Calgary Association of Graduate Nurses in 1904. They saw a need for better communication between nurses isolated by vast distances in Alberta (CNA. (1968). The leaf and the lamp. Ottawa: Author, p. 71).

[107] CNA. (1968). The leaf and the lamp. Ottawa: Author, p. 84; CNA. (1926?). A brief history of the Canadian Nurses Association. Winnipeg: Author, p. 38.

Service Ideal

The service ideal component of a profession could be readily identified throughout this time period perhaps because of its close association to Christian values in Canada and Alberta. One early example of a high service ideal by nurses involved the Grey Nuns at the Edmonton General Hospital. Following an announcement in the Edmonton Bulletin on January 30, 1899 that the medical board of the hospital had resigned, the Sisters of Charity replied:

> We desire that it should be well understood by all that the doctors' resignation...does not carry with it any change in the administration of the hospital, except, however, the fact that the medical board of Edmonton resign the obligation which they had voluntarily and kindly taken upon themselves to attend pauper patients for the space of a month alternatively. Such being the case, the hospital authorities will see that pauper patients are not neglected, but rather received and cared for in the hospital as before; at least as long as the sisters of charity have the means to do so, and the physical strength absolutely required to nurse them day and night if necessary. [108]

These women showed incredible strength in their response to this political move for power by the doctors. [109] Not only did

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[108] Staff. (1899, February 2). Edmonton General Hospital. Edmonton Bulletin, p. 2.

[109] Kerr, J. R., & Paul P. (1990, June). The work of the Grey Nuns in Alberta-1859-1899: A feminist perspective. Proceedings of the Third Annual Conference of the Canadian Association for the History of Nursing (pp. 49-63). Calgary, Alberta: Canadian Association for the History of Nursing, p. 60. These authors suggested that the real reason the doctors resigned was due to their lack of control and authority in the Hospital.

they meet the challenge presented by the resignation of the board in a polite and direct manner, but they refused to compromise their administration of patient care or their service ideal.

At the CNATN first general meeting on May 22, 1911 at Niagara Falls, M. A. Snively challenged nurses to expand their professional responsibilities:

> Associations for social and moral reform, mental and physical hygiene, and many other kindred organizations, all emphasize the fact that our hospital training is merely the beginning of our professional life....As teachers, advisers, or demonstrators in the home, present-day nurses assist in promulgating the great principles underlying good health, as well as aiding those who are suffering from disease. They are the factors for good in the development of the nation. [110]

Ethel Johns described the ideals of public health nursing in 1918 as being: courage, tolerance, humour, vision, adequate educational preparation, and unselfish cooperation. She visualized broadening health care services to include the nurse as a "teacher of health" and the nurse as an agent for "social betterment." She continued:

> To keep your ideals in spite of disappointments and difficulties will not always [be] easy...unless you bring to your tasks some of the divine fire of idealism, you will fail in measuring up to your opportunities, for it is for you to

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[110] CNA. (1926?). A brief history of the Canadian Nurses Association. Winnipeg: Author, p. 22.

> kindle a flame....My ideal of a public health nurse...a bringer of light to those dark places--that they may rise and go forward safely to a saner, healthier way of living....The public health nurse should...be young enough to have enthusiasm and be old enough to have sense....She will be of an age when courage is tempered with discretion, but not so much tempered as to be overcome. Be bold! Be bold! Be not too bold! [111]

Code of Ethics

There was no formally adopted written code of ethics to help guide the practice of the nursing profession in Canada or in any other country in the late 1800s or early 1900s. Frequently versions of the Hippocratic Oath or the Nightingale Pledge were used to fill this void. [112] Isabel Robb devoted a book to ethics: "The science that....teaches men the practice of the duties of human life and the reasons for what they should do and for what they should leave undone." She continued,

> Why should there be this lack of harmony in our nursing ranks....The answer is that we have...a body of women, enlisted in the same profession and under the same obligations, but in whose development no generally recognized ethical laws have had a part. By this it is not meant that trained nurses have lived thus far beyond the pale of ethics, but that, generally speaking, as members of one profession, they have been without an adopted code....Ideas of special moral responsibilities have been vague and indefinite

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[111] Johns, E. (1918). Ideals in public health nursing. The Canadian Nurse, 14 , pp. 909-910.

[112] Hippocrates. (1849). The genuine works of Hippocrates (Trans. F. Adams). New York: William Wood, pp. 278-280; Jones, M. C. (1909). The Hippocratic oath. The American Journal of Nursing, 9, pp. 256-260.

> to the many, while the few have evolved them for themselves as a result of observation and experience....As a profession, we...feel an increasing necessity for some such definite moral force or laws that shall bind us more closely together in this work of nursing, and that will bring us into more uniform and harmonious relations. [113]

In Nursing Ethics , she defined "etiquette" as, "the code of polite life and...forms of ceremony to be observed." [114] "Etiquette" would seem to be congruent with the role of women in society during the late 1800s and early 1900s. Although Isabel Robb never suggested a subservient position for the nurse, her ideas as to "etiquette" could be easily misinterpreted by someone with less concern for the rights of nurses and women. The influence of some of these rules of conduct on the autonomy of nurses was examined over the next decades. [115]

The CNATN addressed the following needs to become a worthy profession: (a) to pass registration laws and take the

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[113] Robb, I. H. (1900). Nursing ethics. Cleveland: Koeckert, pp. 10-11, 13.

[114] Robb, I. H. (1900). Nursing ethics. Cleveland: Koeckert, p. 15.

[115] We have had so much said to us, and written to us, didactically, under the head of ethics, which is not ethics at all. There is, for instance etiquette....Let no one deride or belittle etiquette; it has its place, a very important one. However it is not to be mistaken for ethics. Etiquette, used needless to say, within resonable bounds, is like a common language. Its purpose is to avoid confusion in daily life and to introduce order by establishing one definite and generally understood set of good manners in the place of two or three hundred kinds of good manners, which, like different languages, may only be understood by those who use them.
(Dock, L. L. (1900). Ethics--or a code of ethics? In L. L. Dock (Ed.), Short papers on nursing subjects (pp. 38-39). New York: Longeway)

first steps toward autonomy as a profession, (b) to standardize and improve nursing education and to publish a journal as an organ to unite and educate nurses, and (c) to have a service ideal in nursing, and to become involved in social issues through political activity and collaboration. Although it recognized the importance of a written code of ethics to direct nursing practice it was not expressed as an early priority of the association.

In Alberta a number of professions were establishing themselves as autonomous with the passing of their professional acts. During the first session, bills were presented to establish provincial associations for druggists and chemists, [116] dentists, [117] and physicians and surgeons. [118] The valuable contributions of nurses during World War I may have provided some of the impetus for the passing of the act to incorporate the Alberta Association of Graduate Nurses on April 19, 1916. [119] Finally, this organization was recognized

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[116] On May 5, 1906 the bill presented by the druggists and chemists was "thrown out." The government expressed concern as to how they could maintain adequate control of this group of professionals who requested self-government. It was not until December 10, 1910 that The Alberta Pharmaceutical Association Act was passed.

[117] Government of Alberta. (1906). Statutes of Alberta. Edmonton: Author, pp. 131-140.

[118] Government of Alberta. (1906). Statutes of Alberta. Edmonton: Author, pp. 262-276.

[119] In 1914, Eleanor McPhedran reported the progress of the Graduate Nurses Association of Alberta in drafting nursing legislation:

as a legal entity, and thus, provided the nurses of Alberta with a foundation from which to further develop their profession.

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> It may interest you to know that we hope to place the nursing profession on a par with other professional bodies of the province by arranging that the examinations held be under the control of the Senate of the University of Alberta, and that the register be kept by the Registrar of the University. It was deemed wiser to keep...the standard up to which recognized hospitals must measure under the control of the Nursing Association through their Executive Council. This would facilitate a raising of the standard without recourse to further Act of Legislature.

(McPhedran, E. (1914). Report of the Graduate Nurses' Association of Alberta. The Canadian Nurse, 10(10), p. 635)

## Chapter III

## The Registered Nurses Act is Passed

The day of proclamation of the Registered Nurses Act was a day of celebration for the handful of nurses who spearheaded the formation of a provincial nursing association in Alberta. [120] This event was also the first step in some significant challenges for the the Alberta Association of Graduate Nurses [AAGN], designated to administer the provisions of the Act.

From 1916 to 1930 concerns related to the development of health care services were expressed by the public and by government. It was a time of growth in the health care sector in response to the increase in population. This growth was reflected in an increased number of hospital beds and hospitals, leading to a greater need for nurses. Public health nursing and district nursing was introduced by the government. Health and hospital boards were being organized across the province, and non-government agencies were responding to gaps to government health care services with independent initiatives.

Within the AAGN issues regarding registration, internal administration and training school criteria had to be met. In the province women were struggling for recognition and equality.

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[120] Government of Alberta. (1916). Statutes of Alberta. Edmonton: Author, p. 288. The following nurses were named as the original incorporators in the act: Eleanor McPhedran, Lilian Armstrong, Lottie M. Edy, Martha E. Morkin, Mary Patterson, Edith Rutherford, Margaret Walsh, Lottie Hunter, Agnes Hurcomb, Hester McKay, Sara Kingston, and Victoria Winslow.

Women's groups also played an active role in trying to improve health and social services for women and children. In this chapter the impact of the AAGN on health care services and health policy was examined considering the many influences of the time period.

The Registered Nurses Act set the foundation for nursing to evolve as a profession in its own right. In an attempt to ensure autonomy, the incorporating act stated that the AAGN,

> May pass by-laws not inconsistent with this Act for the government and discipline of its members, the management of its property, the registration and admission of members, and all such purposes as may be deemed necessary for the management of the association, and the promotion of its welfare, and may issue registration certificates. [121]

Foundations for a service ideal and ethical practice were established by provisions that allowed,

> The council to revoke any certificate by an unanimous vote for dishonesty, a habit rendering a nurse unsafe to be trusted with or unfit for the care of the sick, conduct derogatory to the morals or standing of the profession of nursing, or any wilful fraud or misrepresentation practised in procuring such certificate, or the fraudulent use of the certificate. [122]

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[121] Government of Alberta. (1916). Statutes of Alberta. Edmonton: Author, pp. 288-294. Alexander Grant MacKay, Minister of Municipal Affairs and Health and MLA for Athabasca, has been credited with helping the act to be passed unanimously (Cashman, T. (1966). Heritage of service. Edmonton: AARN, p. 114; Jamieson, H. C. (1947). Early medicine in Alberta. Edmonton: Douglas, p. 74).

[122] Government of Alberta. (1916). Statutes of Alberta. Edmonton: Author, p. 293.

When the first organizational meeting was held on Wednesday, October 11, 1916 [123] ninety-one nurses had been registered. Eleanor McPhedran as registrar was paid two hundred dollars for 1916 and thereafter twenty-five dollars per month. One of the first priorities of the group was to increase membership to ensure the association would be representative of Alberta trained nurses. Eleanor McPhedran, Lottie Edy, and Edith Rutherford formed a committee which was to circulate to all graduate nurses in the province the aims and rules of the AAGN, as well as registration forms. It was crucial for the AAGN to put energy into building its membership to ensure its role as the leading provincial association for nurses. One of the barriers to registration may have been the initial fee structure of the AAGN, twenty dollars for registration and ten dollars for examination fee, which was a considerable expense for hospital and private duty nurses. The fee was set by the *pro tem* council [124] upon incorporation of the AAGN. Notably all of the council members were employed in senior nursing positions with higher salaries. On January 31, 1917 the executive reduced the registration fee to ten dollars [125] to make registration more accessible to the

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[123] AAGN. (October 11, 1916). Minutes. Calgary, AB. The meeting was held in the office of a solicitor, George H. Ross.

[124] The majority were superintendents of nursing, instructors or public health nurses with full time permanent employment (Cashman, T. (1960). Heritage of service. Edmonton: AARN, pp. 115-116).

[125] AAGN. (January 31, 1917). Minutes. Calgary, AB.

hospital nurse who was earning as little as forty to forty-five dollars a month. [126]

The act also provided that a graduate nurse was someone who had completed two years of training in medical, surgical, and obstetrical work in a general hospital. After January 1, 1917 nurses failing to meet these educational standards had to write examinations set by a group of Alberta physicians and members of the AAGN who were appointed by the Minister of Education. [127]

At the January 31, 1917 AAGN executive meeting, it was decided that registered nurses from provinces requiring equivalent educational standards would be allowed to register without writing the examination. At that meeting a committee was struck to examine and report to the Minister of Education on the preliminary education for entrance, courses of study, and content of final examinations. [128]

During this period there was a rapid expansion of hospitals to provide services to the growing population. Nursing students, being an inexpensive source of labour, were providing most of the hospital nursing care. This trend lead to concerns by the AAGN as

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[126] Editor. (February 22, 1916). Lady superintendent for city's three hospitals. Edmonton Bulletin, p. 1.

[127] On July 1, 1918, Mr. Boyle, Minister of Education, appointed: Dr. D. G. Revell (president of the AMA), Dr. T. J. Norman (provincial Medical Officer Health [MOH]), Victoria Winslow, Christine Campbell, Sister Duckett, Lottie Edy, and Sister Laverty (AAGN. (June 28, 1918). Minutes. Edmonton, AB).

[128] AAGN. (January 31, 1917). Minutes. Calgary, AB.

to the range of experiences available to nursing students in small hospitals and to the quality of instruction available with so few graduate staff nurses. In order to address the standard course of study for all training schools in Alberta, a committee was formed with representation from the Senate of the UofA, AMA, superintendents of training schools and the AAGN council. Each of these groups was to examine the following questions: (a) What should be the standard of education required of those entering training schools? (b) What should be the minimum number of beds required in a hospital before establishing a training school? and (c) What should be the minimum number of graduate nurses on the staff of a hospital before establishing a training school? [129] This collaborative approach to setting standards for the profession may reflect the political astuteness of the AAGN council as a new profession having to work with the well established male dominated institutions.

The AAGN council recognized the need for continuing education for trained nurses and planned summer classes with the cooperation of Dr. Kerr, Dean of Arts and Science at the UofA. [130] A series of lectures were presented for trained nurses at the same time the first set of registration examinations were held October 1-3, 1918 in Calgary. [131] The AAGN council proposed

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[129] AAGN. (December 13, 1917). Minutes. Calgary, AB, p. 27.

[130] AAGN. (May 7, 1918). Minutes. Edmonton, AB, p. 29.

[131] AAGN. (June 28, 1918). Minutes. Edmonton, AB.

establishment of an annual scholarship for each hospital having one hundred or more beds. The hundred dollar scholarship was to be awarded to the nurse with the highest percentage in practical work. It was hoped that the scholarship might act as an incentive to students to take more interest in examinations. [132]

Initially the AAGN did not have representation from the Catholic nursing orders who had established many of the hospitals in the province. In the process of developing standards petitions were received from the Holy Cross Hospital in Calgary and the Edmonton General Hospital regarding "good English education," [133] perhaps arising from the fact these institutions were established and operated by Grey Nuns whose first language was French. Within eighteen months of the petitions being received the first nun, Sister M. A. Duckett from the Holy Cross Hospital became the second vice-president of the AAGN. [134] This early endorsement by the nursing orders significantly strengthened the AAGN as being representative of all Alberta nurses.

In 1917 the Alberta government found it necessary to propose the use of tax dollars to help ensure hospital services for all Albertans. Representatives of the United Farmers Association

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[132] AAGN. (July 1, 1918). Minutes. Edmonton, AB.

[133] AAGN. (January 31, 1917). Minutes. Calgary, AB.

[134] AAGN. (July 1, 1918). Minutes. Edmonton, AB.

[UFA] and the United Farm Women of Alberta [UFWA] on January 24, 1917 unanimously supported the proposed Municipal Hospitals Act. [135] The Minister of Municipal Affairs for Alberta was directed to divide the province into districts which would be run by appointed hospital boards. These hospital boards would use municipal taxes to support their work in building, maintaining, equipping, and staffing hospitals. [136] The following was stated in the Act:

> The board of any hospital district may make an agreement with the Government of the province as to cost and methods of specially training any number of nurses so as the better to fit them to become superintendents of the district hospital, and as to what proportion of such cost the province shall pay. [137]

The AMA and CMA supported the Municipal Hospitals Act as a step toward providing access to hospital services for all citizens. [138]

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[135] Editor. (January 24, 1917). U.F.A. convention unanimous in its approval plan for rural hospitals recently submitted to government. Edmonton Bulletin, p. 1.

[136] Government of Alberta. (1917). Statutes of Alberta. Edmonton: Author, p. 39. The Municipal Hospitals Act was subsequently assented to April 5, 1917.

[137] Government of Alberta. (1919). Statutes of Alberta. Edmonton: Author, pp. 73-91. This act was revised in 1921, 1922 , and 1924 with each amendment the act became more complex and detailed with need for more bureaucratic control.

[138] The eleventh annual meeting of the AMA passed a resolution supporting the "establishment of cottage hospitals throughout the rural municipalities, the management of such hospitals to be left in the hands of a committee and to be made as largely self-supporting as possible" (Editor. (1916). Alberta medical association. The Canadian Medical Association Journal, 6, p. 1134); Editor. (1919). The free public hospital movement, The Canadian Medical Association Journal, 9, pp. 360-361.

There was no record in the AAGN minutes of a discussion of this Act or the nursing profession's position on it.

On April 5, 1917 the Registered Nurses Act was amended to exempt nurses in training from the examination requirement in becoming registered nurses. The AAGN council made its first stand to ensure the autonomy of its profession when it prepared a resolution to be sent to the government protesting this amendment as it had not been the AAGN's recommendation. [139] Surprisingly, when the resolution was presented to the general assembly for endorsement on December 13, 1917, a motion was carried stating that "no action be taken at present regarding the amendment." [140] AAGN minutes were usually brief with little description of council discussions, particularly with regard to controversial issues. No explanation was given concerning the rejection of the council resolution. Perhaps the general membership agreed with the government's amendment and did not see the necessity of creating conflict over the principle of professional autonomy.

The Calgary Association of Graduate Nurses on May 6, 1918 petitioned the AAGN to consider affiliation with the UFWA. In the July 1, 1918 minutes the AAGN stated that they could see no advantage in this affiliation. They did, however, decide to pursue

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[139] AAGN. (May 23, 1917). Minutes. Edmonton, AB, p. 24.

[140] AAGN. (December 13, 1917). Minutes. Calgary, AB, p. 27.

with Mary McIsaac, who was superintendent of the Women's Institutes, the advantages and disadvantages of affiliation with the Institutes.

The Department of Agriculture helped to establish, organize, and maintain Women's Institutes. These institutes were greatly involved in attempting to ensure quality of life for Albertans. An institute train travelled around the province providing educational programming and child care while mothers attended lectures on various health and social service topics (i.e., home nursing and first aid) and visited the exhibits. Local institutes organized services that responded to the health care needs of their particular community, for example: (a) a scheme for municipal hospitals; (b) a building from which a district nurse could work; (c) medical inspection of schools; (d) a doctor to provide free treatment for outlying districts; (e) hot lunch programs and nutritional classes for children; and (f) rest rooms where country women could rest, relax and visit when in the town. [141]

No further discussion of the affiliation of the AAGN and the Women's Institutes was noted in the AAGN minutes. This should not be interpreted as lack of support by individual nurses of the program. Two of the three staff members of the Institutes were

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[141] Editor. (March 8, 1918). Women's institute work plays big part in Alberta. Edmonton Bulletin, p. 5. The Women's Institutes sponsored short courses in home nursing and first aid in 54 centers to over 3,000 women in 1918.

registered nurses, [142] and many non-working and working nurses would probably have supported the Institutes on an individual basis because of the congruency with the philosophy underlying nursing.

With the end of the war and the armistice signed November 11, 1918 [143] the major problems facing all levels of government were how to reabsorb the returning men into the work force, how to care for the disabled, and how to care for the dependents of the disabled and the dead. More than 600,000 Canadians fought in World War I with 60,661 losing their lives. The high loss of life due to the war was almost exceeded by the additional devastating toll of 50,000 deaths during the epidemic of 1918-1919. [144] The deaths were primarily due to pneumonia, a complication of Spanish influenza. An announcement in the Edmonton Bulletin ,October 4, 1918 stated "Spanish 'Flu Has Reached The Province." The worst death rate occurred between the ages of 25 and 35

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[142] Government of Alberta. (1922). Revised statutes of Alberta. Edmonton: Author, pp. 2113-2122; Cashman, T. (1966). Heritage of service. Edmonton: AARN, pp. 113, 115.

[143] August 24, 1926 a national memorial was dedicated in the Hall of Fame of the Parliament Buildings in Ottawa to commemorate the forty-seven Canadian nurses who gave their lives in World War I (Editor. (1926). Report of the unveiling ceremony of the memorial to the Canadian nursing sisters. The Canadian Nurse, 22, pp. 536-543).

[144] Marsh, J. H. (1985). The Canadian encyclopedia. Edmonton: Hurtig, p. 881; Editor. (November 15, 1918). How nurses and relief workers fought the epidemic in Calder. Edmonton Bulletin, p. 1; Editor. (November 12, 1918). What should you do if you get the 'flu. Edmonton Bulletin, pp. 1, 12.

years for both males and females. From October 4, 1918 to January 1919 the Edmonton Bulletin described in detail the overwhelming community response to the flu epidemic. Temporary hospitals were set up in schools, while volunteers helped nurses, provided meals and cleaned. The trains acted as the air ambulance of today transporting the nurses and physicians throughout the province so that they could both assess the extent of the epidemic and also provide the necessary "expert" care to supplement the work of the community volunteers. A number of preventive measures were attempted: (a) quarantine measures were established, but proved difficult to enforce; [145] (b) vaccines were developed; [146] and (c) laws were passed regarding the wearing of a mask. [147] According to Dr. Whitelaw, none of these measures had much impact on the control of the epidemic. [148]

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[145] Editor. (November 15, 1918). How nurses and relief workers fought the epidemic in Calder. Edmonton Bulletin, p. 1; Whitelaw, T. H. (1919). The practical aspects of quarantine for influenza. Canadian Medical Association Journal, 9, p. 1074.

[146] Editorial. (1919). The Canadian public health association. Canadian Medical Association Journal, 9, pp. 645-646.

[147] Even Dr. J. Park, chairman of the city board of health, was expelled from court by Magistrate P. C. H. Primrose "for contempt of court in that he did appear without being properly and lawfully clothed with a mask" (Editor. (November 15, 1918). Chairman city board of health is fined for not wearing mask. Edmonton Bulletin, p. 4).

[148] Whitelaw, T. H. (1919). The practical aspects of quarantine for influenza. Canadian Medical Association Journal, 9, p. 1074. Olive Whitelaw, T. H. Whitelaw's wife, was a member of the AARN.

The war and the Spanish flu left Canada in 1919 in a state of social and economic chaos. In response to the incredible loss of life particularly of young male adults, Federal and Provincial governments passed a number of Acts. The Department of Health Act [149] stated, "The duties and powers of the Minister administering the Department of Health shall extend to and include all matters and questions relating to the promotion or preservation of the health of the people of Canada over which the Parliament of Canada has jurisdiction." In 1919 The Public Health Nurses Act [150] was passed. It requested that nurses of the AAGN become members by registering and agreeing to help "when possible, in case the Provincial Board of Health declares that any disease in any part of the province has become epidemic or pandemic." A free public health diploma course was established at the UofA for nurses who registered under the Public Health Nurses Act. The course was removed from the Act in 1922 for reasons of economic restraint. The VON provided scholarships to

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[149] Dominion of Canada. (1927). Revised statutes of Canada. Ottawa: Author, pp. 2057-2059. Federal responsibilities included: (a) coordinating child welfare and public health programs; (b) establishing a laboratory for research work and public health; (c) providing medical care for immigrants and seamen; (d) supervising all methods of transportation with regard to public health; (e) supervising federal buildings and offices in order to conserve and promote health of government employees; (f) enforcing public health regulations related to international agreements; (g) administrating the Quarantine, Public Works, Leprosy, and Proprietary or Patent Medicine Acts; and (h) collecting and publishing statistics related to health and conditions affecting health.

[150] Government of Alberta. (1919). Statutes of Alberta. Edmonton: Author, Chapters 16 & 17.

set up post graduate courses in public health at the UofA commencing in 1921.

The minutes of the AAGN do not record any discussion about the Public Health Nurses Act until after its proclamation. During the period of public health developments, from 1918 to 1919, the members of the AAGN were occupied with several other issues: (a) amendments to The Registered Nurses Act, (b) the first registration examinations and lecture series, (c) the organization of the first summer school program, (d) the organization of a committee to recommend a standardized curriculum for training schools, (e) the ending of the war, and (f) the nursing care of the thousands of victims with Spanish Flu. It was not until the June 2, 1919 meeting, Mr. Bishop, the AAGN lawyer was asked to review how the Public Health Nurses Act would relate to the Registered Nurses Act. Finally on October 20, 1919, Victoria Winslow and Lottie Edy were appointed by the AAGN to speak to the Minister of Public Health to obtain explanations and interpretations of the act and to suggest "the word 'registration' be eliminated as somewhat confusing with registration under The Registered Nurses Act, and that nurses in the Public Health service should be required to register under The Registered Nurses Act."

The public health nursing service was developed by Dr. H. C. Jamieson along the lines of the Manitoba program. The first superintendent in Alberta was Christine Smith. In 1921, she

resigned and became director of the post-graduate course for public health nurses at the UofA. [151] The first four public health nurses were Elizabeth Clark, Maud Davidson, Gladys Thurston, and Bessie Sargeant [152] In 1919, Elizabeth Clark promoted district nursing after a tour of the province established in her mind a need by women for help in childbirth. The first district nurses had nursing experience during the war: Mary Sterritt and Genevieve Hefferman worked north of Peace River at Griffin Creek and Mary Hall worked at Yeoford. District nursing was organized with full community participation. The community was responsible for assessing the need, for requesting the service, for providing the nurse with a place to live and work that met departmental standards, and for providing the nurse with transportation. [153] Elizabeth Clark indicated the importance of consulting with the community to ensure the acceptability of health programs when she said,

> Rural organization is not difficult if the aims and objects of the work are clearly presented to the people. The well established farmer and the new settler soon realize that a Public Health Nurse is an asset in their district, and that

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[151] Editor. (1921). Editorial. The Canadian Nurse, 17, pp. 81, 91-92.

[152] Rutherford, E. (1918). Public health nursing in Alberta. The Canadian Nurse, 14, pp. 1304-1305; Cashman, T. (1966). Heritage of service. Edmonton: AARN, p. 156.

[153] Schartner, A. (1982). Health units of Alberta Edmonton: Co-op, pp. 54-61.

good health is one of the most important factors in building up a community. [154]

Citizen participation in health care services became essential during the war because of the lack of trained personnel in Canada and overseas. Groups such as the St. John Ambulance Association [155] and Canadian Red Cross [156] helped to meet this need. These organizations proved to be valuable to the health care system, and many remained after the war, seeking to fill identified gaps in services. The importance of children being involved in health promotion and disease prevention was discussed by Elsie Graves when she discussed the post-war work of the Junior Red Cross. [157]

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[154] Editor. (1922). Public health nursing department. The Canadian Nurse, 18, p. 630. E. Clarke was the convenor of the public health committee of Alberta.

[155] Dominion of Canada. (1914). Statutes of Canada. Ottawa: Author, pp. 309-312. The original branch of St. John Ambulance Association was established in Canada in 1910, however, the association was not incorporated until June 12, 1914. Member of Parliament Dr. Michael Clark from Red Deer was one of original members noted in the statute.

[156] AAGN. (January 30, 1920). Minutes. Hotel Macdonald, Edmonton, AB. Victoria Winslow and Lottie Edy were appointed representatives of the Provincial Red Cross Society Peace Programme (AAGN. (May 14, 1920). Minutes. Calgary, AB.

[157] The Junior Red Cross was begun in Quebec where children were recruited in 1914 to help make surgical dressings. By 1927 there were nine and one half million children around the world involved in this program. In 1925 Jean Browne was honored with Dr. Rene Sand as the two foremost exponents of Junior Red Cross in the area of health (Junior Secretariat. (1925). The international development of the Junior Red Cross. The Canadian Nurse, 21, pp. 285-289; Benedict, E. G. (1927). The contribution of the Junior Red Cross to public health. The Canadian Nurse, 23, pp. 451-457).

In July, 1919 the CNATN at its annual meeting discussed these organizations and their post war work. The Red Cross and the CNATN established a strong collaborative and cooperative bond. [158] By 1920, the Red Cross Society was involved in helping to provide public health nursing services for rural Canada and scholarships for nurses to take specialist training in public health. The CNATN in 1919 had recommended that the provincial presidents of the nursing associations sit on the provincial executives of the Red Cross Society and that nurses enroll and register for any national needs and disasters. When this matter came to the AAGN for discussion, it was suggested that any collaborative efforts in this area be coordinated with the Minister of Public Health who had already taken responsibility for enrollment under the Public Health Nurses Act.

The Public Health Nurses Act also helped to establish nursing in schools. Initially screening of school children had been the work of physicians. [159] The theme for the sixth annual AAGN

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[158] CNA. (1926?). A brief history of the Canadian Nurses Association. Winnipeg: Author, p. 51. Possibly this bond was fostered by Jean E. Browne (later Mrs. W. H. Thomson) who held leadership roles in both, the National Director of the Junior Red Cross (1922-1950) and President of the CNATN (1922-1926) (The Canadian Red Cross Society. (1962). The Role of one voluntary organization in Canada's health services. Toronto: Author, p. 57; Cashman, T. (1966). Heritage of service. Edmonton: AARN, p. 178).

[159] CNA. (1926?). A brief history of the Canadian Nurses Association. Winnipeg: Author, p. 49.

convention was nursing in schools, [160] an indication of support by the AAGN for the direction being taken in public health.

The end of the war lead to the development of health policy in areas other than public health. Louise McKinney, [161] MLA for Claresholm, advocated for many health and social reforms: (a) mother's pensions; (b) care of mentally defective girls until eighteen years old; (c) programs for female prisoners; (d) shorter working hours for student nurses; (e) free care of tuberculosis patients; (f) better housing; (g) better sanitation laws; (h) safeguards for working girls; (i) employment of women school inspectors; (j) education classes for immigrants; and (k) enforcement of the liquor act as it, "Touched every phase of economic life." [162] The AAGN made one of its few comments on social policy when it supported a CNATN resolution for dominion prohibition on February 10, 1919. [163] Interestingly, there was no

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[160] AARN. (November 8-12, 1921). Minutes. Edmonton, AB.

[161] Louise McKinney advocated for women in politics, so they could provide the feminist perspective to all issues (Marsh, J. H. (Ed.). The Canadian encyclopedia. Edmonton: Hurtig, p. 1062; Editor. (February 28, 1919). Local council of women vote. Edmonton Bulletin, p. 8).

[162] Editor. (February 11, 1919). Mrs. L. McKinney, member for Claresholme, discusses liquor traffic problem in province. Edmonton Bulletin, p. 1.

[163] AAGN. (February 10, 1919). Minutes. Edmonton, AB. The prohibition bill was passed March 9, 1916 (Editor. (March 10, 1916). Alberta legislature. Edmonton Bulletin, p. 1); In 1923, the prohibition law of Alberta was rescinded by a provincial plebiscite (Editor. (April 23, 1923). Ballot adopted by legislature after lengthy word battle. Edmonton Bulletin, p. 1); The Government Liquor Control Act of Alberta was passed in 1924 (Government of Alberta. (April 12, 1924). Statutes of Alberta, pp. 125-174).

mention in the AAGN minutes of Nursing Sister Alice Mary Blackwell Turner's struggle and victory for gender equality when she claimed a homestead in Peace River under the Soldier Settlement Act after World War I. [164]

This was also a period during which the AAGN and other nurses in Canada sought to improve the working conditions of nurses. In February 1919 the AAGN unanimously supported an eight hour day for nursing students. [165] This position clearly did not extend to eight hour shifts for all nurses. At the CNATN eighth general meeting in Vancouver July 2-5, 1919, the following resolution was passed,

> That the Canadian National Association of Trained Nurses disapproves of the eight-hour day for graduate nurses on special duty in hospitals, but recommends that no nurse should be allowed on duty longer than twelve hours consecutively in hospitals. [166]

The idea of eight hour shifts for all workers was supported in the NCWC government platform of 1920, however, it took many more years after the rest of the work force had an eight hour work day before this concession was extended to include student and

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[164] Cashman, T. (1966). Heritage of service. Edmonton: AARN, pp. 109-110, 158-159. Mary Blackwell helped to form a Red Cross blood donor clinic in Edmonton during World War II.

[165] AAGN. (February 10, 1919). Minutes. Edmonton, AB.

[166] CNA. (1926?). A brief history of the Canadian Nurses Association. Winnipeg: Author, p. 48.

graduate nurses. At its September 19, 1924 meeting, the AARN council again deferred the resolution concerning nursing hours to the November, 1924 convention for discussion. At the ninth annual AARN convention on November 11-12, 1925, the resolution was finally considered, however the minutes report approval of 12 hour days not the 10 hour days requested by the private duty section of the CNA. A report in the AARN minutes from the Alberta private duty section on November 23-24, 1926 stated, "Through the co-operation of the hospitals the hours have been considerably improved, but it is mostly in private homes where relief is difficult to obtain and funds do not permit for two nurses, that the most serious obstacles present themselves." At least one of the AARN executive, Lottie Edy at the Calgary General Hospital, instituted the eight hour shift for hospital nurses. In ,1923 she resigned as a protest for being directed by the hospital board to stop this practice. [167]

A second concern arising from working conditions related to The Minimum Wage Act which should have provided protection for student nurses who were being sent out to do private duty while the hospital collected their wages:

> Where an employee being a person to whom a minimum wage fixed by the Board applies is an apprentice or learner her employer shall not receive directly or indirectly from her or on her behalf or on her account any payment by way of premium.

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[167] Cashman, T. (1966). Heritage of service. Edmonton: AARN, p. 115.

However, this practice continued into the 1930s despite the law and protests by the CNA and AARN. [168]

On April 17, 1919 the registration examinations were placed under the control of the Senate of the University in an arrangement similar to that between the College of Physicians and Surgeons and the UofA. [169] A provision was made for nurses registered in other parts of Canada or in the USA to receive registration in Alberta without examination if the Senate was satisfied that their qualifications were equivalent to Alberta's standards. According to the minutes of the AAGN these amendments were first proposed at the January 31, 1917 meeting in Calgary. Victoria Winslow, Eleanor McPhedran, and Lilian Armstrong were appointed to approach the government about making these changes. Possibly the busy schedule of the Legislature with the ending of the war, the work of resettlement of soldiers, and other health legislation being proposed lead to the decision of the council at its meeting of October 4, 1918 to wait before approaching the government about amendments to the Registered Nurses' Act. It was not until February 11, 1919, that

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[168] Government of Alberta. (1925). The minimum wage act. Statutes of Alberta. Edmonton: Author; CNA. (1926?). A brief history of the Canadian Nurses Association. Winnipeg: Author, p. 67.

[169] Government of Alberta. (1919). Statutes of Alberta. Edmonton: Author, p. 269. The University of Alberta in 1913 initiated a program to teach medicine. In anticipation of this relationship with the UofA, in 1912, the "Council of the College of Physicians and Surgeons requested that the University take over the registration examinations" (Jamieson, H. C. (1947). Early medicine in Alberta. Edmonton: Douglas, p. 54).

Victoria Winslow, Francis Macmillan, Lottie Edy, and Edith Rutherford met with Mr. MacKay, Minister of Health. He agreed at this meeting to present the amendments to the legislature.

The amendments to The Registered Nurses Act of April 10, 1920 included: (a) a name change to "Alberta Association of Registered Nurses" [AARN]; (b) an increase in minimum training requirement from two to three years; (c) a provision allowing nurses not registered in any other province, state or country, but with equivalent training qualifications to Alberta's standards, to also be registered in Alberta without examination; and (d) a decrease of the registration fee from ten to five dollars. [170] Another step toward self-government and control of nursing standards was made in 1920 when along with the use of the initials "R.N." [171] a distinguishing badge was to be worn to make it possible for everyone to recognize that the nurse was registered. In the April 19, 1921 amendment a "grandfather clause" was added to the minimum increase of three years of training, which allowed nurses who were educated in a two year

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[170] Nurses were one of many groups affected by the depressions of the early 1920s. The Edmonton Bulletin changed back to a semi-weekly paper in 1920 from a daily paper. The paper was filled with bankruptcy notices and for cash only business transactions.

[171] At the July 1, 1918 meeting, the issue of the chiropractors using the initials RN was discussed by the council and the matter referred to a lawyer. Nothing more was reported (AAGN. (July 1, 1918). Minutes. Edmonton, AB).

program and who were resident in Alberta on April 18, 1916 to continue to practice nursing in Alberta.

The Senate of the UofA was given authorization to set standards for the following: (a) minimum entrance requirements into nursing as "passed the grade eight examination of the Public School course of the province or has the equivalent educational standing"; (b) minimum bed capacity, classes, lectures of hospitals with training program; (c) subjects and scope of the qualifying examination; and (d) examiners appointed.

Joint sessions were first held between the Alberta Hospitals Association (AHA) and the AARN at the October 1920 annual meeting in Calgary. Dr. Fisher of the AHA initiated the idea. This collaborative and cooperative effort between these two organizations over the next few years proved beneficial to both.

On November, 1921 at the sixth annual convention of the AARN a concern was raised for better representation of the membership on the elected council. From its inception the officers of the AARN had altered very little. [172] The nurses elected to council from 1916 to 1924 included: Victoria Winslow, Lilian Armstrong, Emma Smith, Eleanor McPhedran, Edith Rutherford, Lottie Edy, Nancy Edwards, Sister Duckett, Katie Manson, Francis Macmillan, Christine Smith, and E. Auger. Interestingly Victoria Winslow (president), and Francis Macmillan

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[172] AARN. (November 8-12, 1921). Minutes. Edmonton, AB.

(first vice-president) were not present at the annual convention or at the two prior council meetings. The following paragraph appeared in the AARN minutes of the sixth annual meeting:

> Some discussion arose as to the organization machinery. It was felt that the present method of electing officers was not at all satisfactory, and that the various districts, either geographically or sectionally were not properly represented on the Council. The Legislative Committee was asked to consider some of the resolutions sent in at previous Conventions and to formulate some scheme by which a more simple and adequate method of conducting business could be worked out.

The number of resignations from council over the eight year period would seem to have indicated periods of conflict within the council itself; however the minutes contain little discussion that would provide a picture of the dynamics within the group. A committee of Edith Rutherford, Lottie Edy, and Eleanor McPhedran was to submit a proposal regarding restructuring of the organization to the annual convention the fall of 1922. A number of recommendations for changes to the constitution were submitted for consideration to the September 7, 1922 annual convention. The motion passed stated, "the council continue as heretofore to consist of seven members,--four to be elected one year for a two-year term, and 3 for one year, and afterward to alternate."

At the 1921 meeting Eleanor McPhedran commented that the work of the Secretary-Treasurer and Registrar was becoming "too heavy for her to carry out in conjunction with her other

professional work." [173] While this concern was noted in the minutes, there was no change in the assignment of duties. At the same annual convention the AARN adopted a position on midwifery: [174]

> Resolved that we...realizing the needs of our outlying and sparsely settled districts, feel that we cannot recommend the establishment of the midwife as such in our province; we do not feel that she should assume such responsibilities. We would respectfully recommend that small hospitals be established in the outlying districts with modern equipment and staffed by qualified nurses with special training in obstetrical work, and that some arrangement be made by which properly qualified medical men might be attached to these districts.

This position would seem to be different from the Alberta government's position in the Public Health Nurses Act of 1919 [175] where nurses with a course in obstetrics and the consent of the Minister were given the authority to practise midwifery in designated areas of Alberta.

The UFA began its fourteen years as the governing party in 1921 with Premier Greenfield initially focusing his efforts on trying to provide relief for Albertans destitute due to droughts

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[173] AARN. (November 8-12, 1921). Minutes. Edmonton, AB.

[174] M. Gibson, a district nurse, supported nurse-midwives (Gibson, M. A. (1925). Letter to the editor. The Canadian Nurse, 21, pp. 212-214); Ethel Johns advocated nurse-midwives in isolated districts (Johns, E. (1925). The practice of midwifery in Canada. The Canadian Nurse, 21, pp. 10-14).

[175] Government of Alberta. (1919). Statutes of Alberta. Edmonton: Author, Chapters 16 & 17.

and crop failures. The Maintenance Order Act, [176] made the municipalities responsible for ensuring the care of children and the poor. Realizing that they could not manage to provide enough relief, the Alberta government entered into a cost sharing agreement with Ottawa on October 27, 1921 which was not ratified until March 28, 1922. [177] This need for Federal relief led to a change in the power balance by which the central government became the stronger political force. [178]

The 1921 census indicated significant growth of the nursing profession and a much more conservative growth of the medical profession in Canada and Alberta since 1911. The number of persons calling themselves nurses had increased in Canada by 282% to 21,385 and in Alberta by 200% to 1,084. Physicians and surgeons in the same period had increased in Canada by only 18% to 8,706 and in Alberta by 49% to 548. Perhaps the Flexner report of 1910 on medical education had a similar effect in Canada as it had in the USA, where the consolidation of medical schools into the University settings ensured a standard quality education, thereby decreasing the number of graduates. The number of

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[176] Government of Alberta. (1921). Statutes of Alberta. Edmonton: Author, pp. 77-79. Women were excluded from the responsibility unless "the father is unable and she is able to maintain the person" according to the requirements of the act.

[177] Government of Alberta. (1922). Statutes of Alberta. Edmonton: Author, pp. 59-61.

[178] Lower, A. R. M. (1952). Canada nation and neighbour. Toronto: Ryerson.

physicians and surgeons may have also been controlled by the very inclusive clauses of the Medical Profession Act and the power that they had to be self-governing: "The council shall enter upon the register...any person who produces a certificate from the registrar of the University of Alberta to the effect that the person to whom such certificate is issued is duly qualified to practice, medicine, surgery, midwifery, homeopathy, osteopathy, chiropractic, or any non-drug science, therapy, or system of practice." [179]

The AARN hosted the eleventh general meeting of the CNATN in the MacDonald Hotel in Edmonton on June 19-22, 1922. By 1922 all provinces had registration laws in place. The CNA began to feel the need for a more formal organization with paid staff to meet the objectives of the organization. [180]

The first five year degree program in Alberta was started in 1923 with Margaret McCammon as the first superintendent. Agnes Macleod, Annabel Raver, and Frances Alexander were the first and only three graduates to complete the full course in

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[179] Government of Alberta. (1922). Revised statutes of Alberta. p. 2618. The population in the same period had increased in Canada by 22% to 8,788,483 and in Alberta by 57% to 588,454. In Alberta 62% of the population was considered rural only a 7% increase since 1906.

[180] Following this general meeting a national office was established in Winnipeg and Jean Wilson was hired as executive secretary. It was decided due to economic constraints that general meetings would be held biennially. A fifty cent levy per capita per year was passed to finance these changes in organizational structure (CNA. (1926?). A brief history of the Canadian Nurses Association. Winnipeg: Author, p. 66).

Edmonton until 1937. [181] Because of economic restraints an instructor was not hired after the first class graduated. Consequently, subsequent students had to leave the province to complete their degrees. In 1923 the provincial public health nursing staff had to be reduced from twenty-six to eleven due to lack of funds. [182] R. G. Reid, Minister of Health, announced that services would be maintained in most outlying districts.

The AARN had met on February 8, 1924 to endorse the CNATN recommendations regarding maternal care in rural areas: (a) a yearly bonus for medical practitioners working in outlying districts, (b) outpost hospitals similar to those being established by the Red Cross, (c) nursing housekeepers to assist registered nurses, (d) efficient transportation to medical services, and (e) home nursing classes. [183] This initiative by the CNATN demonstrated the leadership it was taking in ensuring the

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[181] Martha Black, the instructor for the final year, remained only one year and was not replaced (Cashman, T. (1966). Heritage of service. Edmonton: AARN, pp. 157, 163-164). The program at UBC had been started by Ethel Johns in 1919. It was the first university degree nursing program in the British Empire (CNA. (1968). The leaf and the lamp. Ottawa: Author, p. 84; Street, M. M. (1973). Watch-fires on the mountains. Toronto: UofT, pp. 118-119).

[182] "General regret was voiced...by many members that it was necessary to curtail this service....Mr. Reid admitted that it had been organized by the former government on a splendid scale." The house refused to cut the funds for sanitary inspection. The health budget voted on was $907,180.00 (Editor. (April 13, 1923). Public health nurses' staff curtailed but work going on. Edmonton Bulletin, p. 1).

[183] AARN. (February 8, 1924). Minutes. Edmonton, AB. The yearly bonus for physicians and home nursing classes were already being done in Alberta.

development of adequate health care services in Canada. At the 1924 general meeting in Hamilton further restructuring of the CNATN was ratified by the membership. [184] Four provincial representatives were to be on the executive committee of the CNA: the provincial president, and the chairpersons of the provincial public health, private duty, and nursing education sections. This restructuring of the CNA led to restructuring of the AARN. The AARN in its annual report of 1924 discussed the progress in the development of the three sections: (a) the public health section was fully organized with 26 members; (b) the nursing education section had begun in October, 1923 with its principal work being the development of a four-day institute for nurses; and (c) the private duty section was only beginning to be set up with the appointment by the AARN council of a convener, Mary Cooper. The development of these sections ensured all nurses had a voice; however these practice divisions also acted to divide nurses as individuals.

In November, 1925 at the ninth annual convention of the AARN, [185] registration of nurses was a major concern as less than

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[184] Revised by-laws of June 25, 1924 were printed in A brief history of the Canadian Nurses Association (CNA. (1926?). Winnipeg: Author, pp. 95-104). The office of *The Canadian Nurse* was to be moved to the national office in Winnipeg from Vancouver. The name of the CNATN was shortened to the Canadian Nurses Association [CNA]. The Canadian Association of Nursing Education become a section of the CNA. A request came from the NCWC to have the CNA president as a representative on the maternal care committee. A permanent stenographer was employed.

[185] AARN. (November 11-12, 1925). Minutes. Calgary, AB.

fifty percent of women calling themselves nurses in Alberta were registered. [186] A resolution requiring private duty nurses to be registered and to join the local registry was supported by many, but it was recognized that the association had no legal power to enforce such a ruling. Another major concern was that reciprocity of registration with other provinces was in jeopardy because Alberta's training school standards were much lower than Saskatchewan, British Columbia and Quebec. The nursing education section was given the task of improving the curriculum approved by the UofA governing the standards of nursing training in Alberta. [187] The AARN minutes of July 10, 1926 reported the acceptance of the revised curriculum by the Senate. The AARN nursing education section reported on April 21, 1928 that several training schools were having trouble providing for the dietetic and communicable diseases parts of the curriculum. The problem with teaching communicable diseases was stated to be gaining clinical experience due to the decrease in the number of cases of some diseases.

The struggle for autonomy continued during 1926 when in July the AARN passed a motion to write the Minister of Health requesting that the AARN be "allowed to confer" with anyone

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[186] In 1929 there were reported to be 575 nurses registered in Alberta with the last registration number issued being 1434 (AARN. (1929). Annual report. Edmonton: Author).

[187] AARN (May 26, 1925). Minutes. Edmonton, AB.

considering making changes in the training of nurses in Alberta and "calling the Minister's attention to the standards of training established with the consent of the Legislature by the University of Alberta." [188] A slightly stronger message was sent from the membership attending the 1928 general meeting requesting that the Minister of Health give the AARN, "as a body of women interested in nursing as it relates to the Student, to the graduate, and to the needs of the community...an opportunity to discuss with himself and this Advisory Committee on Public Health, questions which so vitally concern our profession." [189]

It was at this time the AARN also became aware of the intentions of the CMA to undertake a national study of nursing training in Canada. The CMA resolution [190] passed at its 1926

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[188] AARN. (July 10, 1926). Minutes. Calgary, AB, p. 205.

[189] AARN. (September 14, 1928). Minutes. Edmonton, AB.

[190] A special committee was appointed by council for the foll. purpose:

1. To study and report upon the curricula of Training Schools for Nurses in Canadian Hospitals.
2. To determine the process by which the present curricula have been evolved and the supreme authority in determining these matters.
3. To request the co-operation in this study from other Canadian organizations directly concerned in the education of nurses, pupil or graduate.
4. To request co-operation also from the American Medical Assn. the American College of Surgeons, the American Surgical Association, the American Hospitals Assn., the American Association of Nurses, etc.

(AARN. (November 23-24, 1926). Minutes. Calgary, AB)

annual meeting in Victoria, was quoted along with a joint response by the AHA and AARN:

> Resolved that the joint meeting of the Alberta Hospitals Assoc. and the Alberta Association of Registered Nurses, deprecate the method taken by the Canadian Medical Association to study the curriculum of the training schools for nurses in Canada as stated in the resolution outlining the functions of the committee, and suggest that this resolution be annulled, and that a joint committee composed of representatives of the Canadian Medical Assn. and the Canadian Nurses' Assn. be appointed to make a study of the question. [191]

The AARN annual report stated that on June 14, 1927 Edna Auger had attended the meeting called by Dr. G. Stewart Cameron, CMA chairman of the survey of nursing education in Canada. The three members of the CNA elected to be on the survey committee were Jean Gunn (Toronto General), Jean Browne (Red Cross), and Kathleen Russell (University of Toronto). The CNA stipulated that only if the survey was thoroughly and scientifically conducted would they participate as an equal partner [192] with the CMA. At the December 27, 1929 meeting, the AARN announced that Dr. George Weir, department head of education at UBC, would conduct the survey. The Canadian nurses took a strong stand against the interference of the CMA in their profession. The nurses managed to turn this almost impossible situation to their advantage by

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[191] AARN. (November 23-24, 1926). Minutes. Calgary, AB. These pages were out of place and had no typed date, however, someone had written in the margin "1926".

[192] CNA paid 70% of the cost of the survey while the CMA paid 30%.

paying the lion's share of the cost of the survey, by taking an equal part in the organization of the survey, and then, by mobilizing their ranks to ensure cooperation and collaboration with Dr. Weir, a non-medical researcher.

The decade ended with a tremendous celebration as Canadian nurses hosted more that 6,000 delegates from twenty countries at the ICN congress in Montreal in July 8-13, 1929. [193] Two other major events occurring in 1929 would significantly change the face of nursing in Canada in the next decade: (a) the crash of the stock market on October 24 [194] followed by the Great Depression of the 1930s, [195] and (b) the beginning of the scientific survey of Canadian nursing education by Dr. Weir.

Health Care Services and Health Policy

In the literature written in the 1920s by lay people or members of the health profession there was frequently an acknowledgment of the need to consider man a physical, mental, and spiritual being and that the health of the individual must consider all these facets. [196] No definition of health was found in the AARN documents of this period.

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[193] Editor. (1929). Nurses attending the congress of the International Council of Nurses. The Canadian Nurse, 25, p. 182.

[194] This historic day received no mention in the Edmonton Bulletin.

[195] Marsh, J. H. (Ed.). (1985). Great depression. The Canadian encyclopedia. Edmonton: Hurtig, pp. 770-771.

[196] Nursing Sister Harris wrote, "The ideal of positive health takes us quite beyond the conception of health in its passive state, a mere freedom from disease, into a vision of complete well-being....a state of comfort,

Disease prevention and health promotion took on a major role in the health care services provided by the Federal and Alberta governments during the 1920s. [197] The development of vaccines decreased the mortality and morbidity of the population significantly from communicable diseases, [198] but by 1927 some of the public were already becoming complacent about being vaccinated as they perceived less personal risk. [199] The importance of early detection of disability and disease led to the

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harmony, ease, not merely in things bodily, but mentally, spiritually and socially." She continued, " Life's Purpose--a struggle for Excellence, Health, Adjustment. Life's Purpose obtained through obedience to Law. Right feeling or attitude the mainspring of action. The child-like quality of tolerance--the open mind" (Harris, S. M. (1926). The positive health ideal. The Canadian Nurse, 22, pp. 257-259); "Man is indeed a threefold creature, indivisible, body, mind and spirit each working for the perfecting of each" (Benedict, E. G. (1927). The contribution of the Junior Red Cross to public health. The Canadian Nurse, 23, p. 456).

[197] Dr. Harris provided a comprehensive report on the public health situation of 1929 in his presidential address (Harris, N. M. (1929). Presidential address: Some thoughts on the organization and progress of public health in Canada. Canadian Journal of Public Health, 20, pp. 375-385).

[198] Hutton, W. L. (1929). The growth of the sanitary conscience. Canadian Public Health Journal, 20, p. 17; Warwick, W. (1929). Convalescent serum in the prevention of measles. Canadian Journal of Public Health, 20, p. 597; Calgary in 1924 had a mortality rate of 22.8 per 100,000 people. Following an immunization program of pre-school and school children the rate fell to 12.8 per 100,000 persons (Hendrie, N. B. D. (1926). Diphtheria prevention campaign. The Canadian Nurse, 22, pp. 252-253).

[199] Roberts, J. (1927). The specific duties of medical officers of health in dealing with communicable diseases. Canadian Medical Association Journal, 17, pp. 1178-1182, 1309-1350.

recommendation of periodic health examinations, [200] medical inspection of schools, [201] and prenatal care. [202]

By the 1920s the trend towards hospitalization of the sick was becoming evident. In 1926 Dr. D. A. Stewart, president of the Manitoba Medical Association stated, "We need more hospitals, better and broader hospitals, more facilities gathered into hospitals, more services radiating out from hospitals, more use of hospitals by the people, better way of supporting hospitals, more hospitals becoming real community health centres." [203] The

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[200] Editor. (1929). Why periodic health examination--an answer written in 1861. Canadian Public Health Journal, 20, p. 148; Editor. (March 28, 1928). Periodic health exams for all urged by social hygiene council. Edmonton Bulletin, p. 1; "If the conditions under which we live were less strenuous and complicated, with more time for rest, relaxation and diversion, with fewer fears and anxieties, the outlook would be even more hopeful" (Anderson, H. B. (1929). The major diseases of adult life as a problem of preventive medicine. Canadian Journal of Public Health, 20, pp. 583-596); Editorial. (1919). The Canadian public health association. Canadian Medical Association Journal, 9, pp. 645-646; Dr. Hattie stated that cardiac disease was the dominant cause of death over forty. He stated that "worry, excitement, and overwork--and perhaps more especially mental overwork" should be considered important factors. (Hattie, W. H. (1919). Death rate above age of forty. Canadian Medical Association Journal, 9, pp. 732-740).

[201] Burke, F. S. (1929). A system of school medical inspection. Canadian Public Health Journal, 20, pp. 6-16; Simpson, R. M., & Emory, F. H. M. (1929). Public health nursing: School nursing. Canadian Journal of Public Health, 20, pp. 515-517).

[202] MacMurchy, H. (1925). On maternal mortality in Canada. Canadian Medical Association Journal, 15, pp. 293-297.

[203] Stewart, D. A. (1927). The care of the sick. Canadian Medical Association Journal, 17, pp. 94-97). Dr. Emerson in 1928 stated that the hospital had "been accepted as a symbol of the community's aspirations for well-being and for the expression of a Christian spirit among men, and as a means of applying the knowledge of science to the prevention and relief of

patient capacity in Edmonton hospitals was greatly increased by 1922 to a total of 740 at a cost $675,000. [204] Some articles discussed the concern by physicians as to who controlled the hospitals. [205]

On February 16, 1928, Fred White, the MLA for Calgary and leader of the Labor party, proposed a recommendation in the legislature that Alberta adopt a system of state medicine where all physicians would be on salary to ensure equitable distribution of health care services. He speculated physicians would object to the idea. [206] Many physicians were indeed disturbed by the idea of

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human suffering" (Emerson, H. (1928). The hospital and the community. The Canadian Nurse, 24, pp. 339-341).

[204] Royal Alexandra (250), Edmonton General (175), Strathcona (150), Misericordia (75), Isolation hospital (90) (Editor. (1921). Alberta. Canadian Medical Association Journal, 11, p. 874); The Calgary Holy Cross Hospital new wing containing 90 beds was completed at a cost of $400,000. A plebiscite to build a new municipal general hospital of 300 beds in Calgary for $1,250, 000.00 was to be voted on in 1929. The old hospital was to be made a nurses' home (Editor. (1929). Alberta. Canadian Medical Association Journal, 20, p. 220).

[205] McKentry, J. (1927). The relations of the medical profession to hospitals. Canadian Medical Association Journal, 17, pp. 151-156; Editor. (1927). The management of hospitals. Canadian Medical Association Journal, 17, pp. 22; Moore, S. E. (1927). Canadian hospital efficiency. Canadian Medical Association Journal, 17, pp. 567-570; Whitelaw, T. H. (1928). Co-operation of health departments and hospitals. Canadian Medical Association Journal, 19, p. 446-449.

[206] Editor. (February 17, 1928). Motion before house. Edmonton Bulletin, p. 1; Editor. (1920). The medical and allied professions as a state service. Canadian Medical Association Journal, 10, pp. 70-73). In 1921, E. M. Dickson, recommended the CNATN study state medicine so that nurses could play an informed role (Dickson, E. M. (1921). Presidential address. The Canadian Nurse, 17, pp. 419-425).

state medicine. [207] Interestingly service ideal and state medicine were seldom mentioned within the same article except to emphasize that "all" physicians did charitable work.
To help improve accessibility and affordability of health care services an outpatient department was set up at the UofA Hospital, [208] and child welfare clinics were set up throughout the province. [209] Perhaps the poliomyelitis epidemic [210] of 1927 spurred the government to make another significant move toward a universal health care scheme. With the passing of The Municipal

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[207] Editor. (1928). Alberta. Canadian Medical Association Journal, 18, p. 244; Editor. (1928). Alberta. Canadian Medical Association Journal, 18, p. 362; Whitelaw, F. H. (1928). State medical service for Alberta. Canadian Medical Association Journal, 18, p. 242; "The Hon. George Hoadley, Minster of Public Health, we are informed is a very successful farmer in Alberta, but success in farming involves little knowledge of medicine, or of the many problems connected with public health and preventive medicine. The Province of Alberta appears to be alone in considering that the public health can be regarded as a matter of business, and be safely entrusted to the knowledge and judgment of a farmer" (Editor. (1928). Medical legislation in Alberta. Canadian Medical Association Journal, 18, pp. 435-436).

[208] Macleod, A. M. (1921). Outdoor Clinic Work in Edmonton. The Canadian Nurse, 22, pp. 420-421. Examination and advice were free, however, the patient was required to pay whatever possible for treatment.

[209] Pauline Bowman of the Medicine Hat General Hospital described a free government clinic similar to the Child Health Conferences of today only a doctor was present (Bowman, P. (1926). Child Welfare Clinic. The Canadian Nurse, 22, pp. 484-485).

[210] The number of cases totalled 354, with Edmonton reporting 101 of these. There were 53 deaths (Jenkins, R. B. (1929). Some finding in the epidemic of poliomyelitis in Alberta, 1927. Canadian Journal of Public Health, 20, pp. 219-224); Alberta had experienced the most severe epidemic of all provinces in 1927 (Editor. (1929). The poliomyelitis situation. Canadian Journal of Public Health, 20, p. 247).

Hospitals Act Amendment Act [211] a "hospital scheme" was introduced with an initial prepaid premium of six dollars per annum for each taxable person and an opportunity for non-tax paying residents to join the program. Other acts [212] passed in 1927 provided a plan for cost sharing the expenses of employing public health nurses for any community to care for all people, not just the indigent. Councils of towns were obligated to provide "care and treatment" of indigents when they were sick. Villages could pay an "inducement" of not more than five hundred dollars to a medical practitioner to encourage "him to reside or practise his profession in the village."

The minutes of the AARN do not reveal any discussion on the preceding health care service and health policy developments. While individual nurses did play a role in some of these developments, it is clear, that as an association the AARN had no impact.

## Status of Women

Perhaps the independence offered women during the war and their new found skills and knowledge gained from war work helped to provide some of the impetus which led to the creation

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[211] Government of Alberta. (1927). Statutes of Alberta. Edmonton: Author, p. 159. The Municipal Hospitals Act, 1929 consolidated and amended previous law related to hospitals. The bureaucracy was growing at an alarming rate (Government of Alberta. (1929). Statutes of Alberta. Edmonton: Author, pp. 297-326).

[212] Government of Alberta. (1927). Statutes of Alberta. Edmonton: Author, Chapter 54 & 55, pp. 226, 231, 331-332, 334.

of more national and local women's organizations. [213] It might have been anticipated that a female profession like nursing would have naturally collaborated with other women's groups in areas of common interest. However, there seemed to be reluctance on the part of the AARN and the CNA to affiliate with many of these groups. Some nursing leaders did encourage collaboration, for instance, Bella Crosby contended in a discussion at the third annual meeting in 1914 when the CNATN was asked to head a department of the magazine, The Woman's Century:

> Our work has not been carried along with the other workers. We have not worked with them, and I think we should co-operate. Some of their workers have been reporting on nurses' work. Now, we do not think that is right, but it is not their fault, it is our fault. We have not co-operated with them in these large things, and I think that we should, and it seemed to me an opportunity for us to identify ourselves with the women's work all along the line. [214]

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[213] By 1912 it was estimated that one of every eight women in Canada belonged to a women's group. However, most of the members were white, middle-class, middle-aged, Protestant, and English speaking. The women banded together to apply pressure for social change and to lessen the isolation of living in a vast country with sparse population. They learned a number of skills related to leadership, group dynamics, raising and administering funds, and political activism particularly with regard to issues of women's rights and children's welfare. According to Wendy Mitchinson, the French speaking Catholic women satisfied their needs for social interaction among females within church groups and sisterhoods. Other groups rallied around particular interests, i.e., music, books, or occupations (Marsh, J. H. (Ed.). The Canadian encyclopedia. Edmonton: Hurtig, p. 1961).

[214] Editor. (1914). Annual meeting. The Canadian Nurse, 10(10), p. 579.

The president of the CNATN, Mary Mackenzie, concurred, "I feel that nurses, for their self-preservation, must go into the public life whether they like it or not. It has got to be done, or we are going to be back numbers." It was decided to appoint someone on the executive to be responsible for the column. [215]

Other first steps toward collaboration and political activity were evident at the 1916 meeting of the CNATN: (a) when a committee was formed to confer with the VON and the NCWC about relieving the medical and nursing needs in sparsely populated parts of Canada and (b) when it was decided to establish an affiliation with the NCWC. Again in 1920 the CNATN passed resolutions that recommended working toward affiliation this time with the Young Women's Christian Association and the Social Service Council of Canada. [216]

In the AARN minutes of May 26, 1925, a resolution from the CNA was approved which recommended the withdrawal from affiliation with: (a) the NCWC, (b) the Social Service Council of Canada, and (c) the Child Welfare Council of Canada. The reasons given were: (a) "the membership in the C.N.A. is strictly conditioned by professional standards, and the organization exists for the maintenance and elevation of these standards" and

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[215] Editor. (1914). Annual meeting. The Canadian Nurse, 10(10), pp. 580-581.

[216] CNA. (1926?). A brief history of the Canadian Nurses Association. Winnipeg: Author, pp. 56-57, 65.

(b) "the C.N.A. does not function apart from its federated units, it is not feasible to be affiliated with National Societies which do not conform to a similar plan of organisation." The Social Service Council of Canada attempted to maintain contact and from the May 26, 1925 minutes the AARN appeared to remain open to some collaboration. On November 19, 1929, it was decided to reapply for membership to the Local Council of Women as, "this body is considering the Medical Inspection of Schools throughout the Province."

By 1929 the NCWC [217] was no longer viewed as the voice of Canadian women. Boag gave some reasons related to the internal organization that may have led to its decline:

> An increasingly authoritarian élite found great difficulty in coordinating a complex club movement of better-educated women. The eastern Canadian orientation of the Executive also complicated matters by alienating western members. Growing bureaucratization, together with the emergence of confident new women's organizations, seriously handicapped the NCWC's progress.

She went on to suggest that it was possible in the class structure of Canada to "richly reward the women as well as the men of the middle class--although not quite to the same degree," therefore women who belonged to the dominant social group like the leaders of the NCWC were not too interested in drastic social change but

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[217] NCWC was incorporated on May 27, 1914 as a voluntary association devoted to improving the conditions of women and children throughout Canada (Dominion of Canada. (1914). Statutes of Canada. Ottawa: Author, pp. 317-318).

rather, "domination... tempered by 'justice and mercy'." Most Canadian women she stated, "accepted the major tenets of the liberal creed--the faith in individual effort, private property, human progress, and natural hierarchy." [218]

One of the most significant events regarding the status of women in the 1920s involved a group of five Alberta women: Emily F. Murphy, Nancy McClung, Louise McKinney, Irene Parlby, and Henrietta Muir Edwards. Following the March 1928 Canadian Supreme Court decision that women were not eligible for appointment to the Senate because according to section 24 of the BNA act they were not considered "persons", the five women hired Newton Wesley Rowell of Toronto and took the case to the Privy Council in London. In October 1929 it ruled within the meaning of the BNA Act that the word "persons" included both females and males. [219] Amazingly this major struggle and victory for gender equality was never mentioned in the AARN minutes.

The nurses of the AARN frequently chose to isolate themselves from other women's groups and tended to focus on

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[218] Boag, V. S. (1979). The roots of modern Canadian feminism. In B. Hodgins & R. Page (Eds.), Canadian history since confederation (pp. 398-408). Georgetown, Ont: Irwin-Dorsey. The NCWC by 1929 had accomplished a great deal of reform:

> The old and ill were no longer usually inmates of the Dominion's jails; infant mortality had fallen; rates of tuberculosis had declined; urban children played in new parks; nonacademic pupils were offered educational alternatives; poor women benefited from mothers' allowances; and all women had at least the federal franchise. (p. 407)

[219] Editor. (October 18, 1929). Mrs. E. Murphy is gratified by decision. Edmonton Bulletin, second section.

professional issues to the exclusion of social or political issues of the local and world communities. Efforts at collaboration were primarily made to promote the nursing profession. A further factor which may have discouraged collaboration was the nature of the work in which most members of the AARN were engaged. During this period most nurses worked in private duty, isolated from one another and working long hours for low pay. Those involved in leadership positions with the AARN would have the additional time commitment in developing the profession to balance with their work.

## Development of the Nursing Profession

It would appear that establishing nursing as a new professional association in Alberta consumed most of the energy and attention of the AARN. Before the AARN could have any effective impact on health care services and health policy it had to have credibility, both in political activity and in numbers.

### Autonomy

In comparing the political activity of the nursing profession and the medical profession, it was clear that the medical profession was far more politically active as elected members of the government and as lobbyists. The Canadian Medical Association Journal played a significant educational role for its members by publishing and analyzing any federal or provincial legislation that directly or indirectly affected the profession. By the end of the decade only one "nurse", Roberta MacAdams had

been elected to the Alberta legislature. Roberta MacAdams was never mentioned in the AARN minutes perhaps because she was a trained dietitian not a trained nurse. [220] Seldom was legislation printed and discussed in the American, British, or Canadian nursing journals. The nurses that were registered were not being educated as were the physicians as to how to influence health policy. Political activity by the AARN was limited primarily to changes in the Registered Nurses Act.

The minutes of the AARN did not contain any references to discussion on health or social issues that did not directly effect nurses. Surprisingly the AARN never discussed: (a) the effect of pornography on the status of women, [221] (b) the ethical dilemma of The Sexual Sterilization Act, [222] (c) the effect on professional autonomy of The Professional Discipline Act of 1928, [223] or

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[220] Cashman suggested that there may be some debate as to whether Roberta MacAdams was really a nurse as she had been trained in household economics at Macdonald College and was commissioned as a dietitian, however, he ended his discussion by stating, "The clincher is that the boys who voted for her thought they were voting for a nurse. The majority rules in a free society. So a nurse became one of the first two women elected to the legislature of Alberta" (Cashman, T. (1966). Heritage of service. Edmonton: AARN, p. 120).

[221] In 1927 The Theatres Act was passed. Censorship rules provided for the, "destruction or removal of posters...displays which are indecent or have an immoral, degrading or objectionable tendency" (Government of Alberta. (1927). Statutes of Alberta. Edmonton: Author, pp. 151-156). The Child Welfare Act stipulated children under eighteen were not to possess pornographic material or to habitually use obscene language in public (Government of Alberta. (1925). Statutes of Alberta. Edmonton: Author, pp. 23-51).

[222] Government of Alberta. (1928). Statutes of Alberta. Edmonton: Author, pp. 117-118. The purpose was to prevent the "danger of procreation with its attendant risk of multiplication of the evil by

(d) the effect on quality of life of The Old Age Pensions Act of 1927. [224]

As individuals private duty nurses, public health nurses, district nurses, nursing administrators, and nursing instructors would be considered to operate quite autonomously in their nursing practice compared to today. Perhaps this independence in practice at the individual level made it more difficult for the profession itself to quickly attain autonomy. The first step would seem to have been the grouping of nurses into alumnae associations and then in the mid 1920s into groups according to fields of practice. The public health nursing section and nursing

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transmission of the disability to progeny" (p. 117). Sir Travers Humphreys stated in his opinion it was illegal to sterilize mental defectives except if, "it could be shown that the operation was necessary to the health or wellbeing of the patient" (Editor. (1925). On birth control. Canadian Medical Association Journal, 15, pp. 1065-1066). The editor of the Canadian Medical Association Journal in 1928 cautioned, "The medical profession may have to assume its share of the responsibility, even though it has done nothing but stand idly by while the legislatures have acted. It seems timely to undertake a study of the field of eugenic sterilization and sexualization now, so that the policy of the Association may be wisely determined" (Editorial comments. 19, p. 586).

[223] Government of Alberta. (1928). Statutes of Alberta. Edmonton: Author, pp. 101-104. This act was to ensure the protection of the public by providing them with an avenue to submit complaints about professionals. The act was supported by the physicians following a meeting to clarify the affect on the autonomy of the profession (Editor. (1928). Proposed enactment effecting profession in Alberta. Canadian Medical Association Journal, 18, p. 399).

[224] Dominion of Canada. (1927). Revised statutes of Canada. Ottawa: Author, pp. 3001-3006. This was a cost sharing arrangement between the federal and provincial governments. A government bureaucracy was quickly growing to administer the act (Dominion of Canada. (1928). Statutes of Canada. Ottawa: Author, pp. 161-171).

education section were quickly organized, however, the private duty section because of the isolation of these nurses took a much longer time to establish. Initially these three sections did not cooperate as a unit within the AARN, therefore, decreasing the power of the professional body and its ability to exert its right of autonomy.

Skill and Knowledge

Much of the work of the AARN and the CNA during the 1920s was concentrated on improving the knowledge and skill of the nurse. Attempts were made to increase the entrance requirements above the grade eight level, to select the most appropriate students through investigating the use of mental testing, [225] to standardize the nursing education curriculum content provincially and nationally, [226] to improve the living and working conditions of student and graduate nurses, [227] and to

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[225] Earle, M. G. (1925). The value of mental testing. The Canadian Nurse, 21, pp. 190-192, 240-242.

[226] Lawrie, A. F. (1928). The building of a curriculum. The Canadian Nurse, 24, 589-593; Gunn, J. I. (1925). How might our curriculum be changed to meet the needs required? The Canadian Nurse, 21, pp. 133-135; Editor. (1925). Editorial. The Canadian Nurse, 21, pp. 177-179; Russell, E. K. (1928). The Canadian university and the Canadian school of nursing. The Canadian Nurse, 24, pp. 627-630.

[227] Macmillan, F. (1922). Home life of the pupil nurse. The Canadian Nurse, 18, p. 6-8; Young, D. A. (1926). The nurse' sick room, Lamont public hospital. The Canadian Nurse, 22, p. 365; Cameron, I. (1922). The nurse's life and calling. The Canadian Nurse, 18, pp. 636-642; Jamieson, A. (1928). Problems of the private duty nurss. The Canadian Nurse, 24, pp. 196-198; Lockwood, A. L. (1928). Group nursing. The Canadian Nurse, 24, pp. 491-494; Moag, M. L. (1929). Hourly nursing. The Canadian Nurse, 25, pp. 138-142.

increase the ratio of classroom theory to ward practical work. [228]

The idea of "trained attendants" first appeared in the legislation in 1920 under section 24(b) of the Hospitals Act. [229] It was proposed that they would "go out into the country and act as assistants and housekeepers where mothers were obliged to leave their family for medical treatment." [230] The AAGN minutes indicated approval by submitting to the Minister of Health a number of recommendations regarding educational programs, functions, and supervision for trained attendants. The Calgary Graduate Nurses Association in February, 1923 influenced a change in policy when they recommended "patients in the country needed the services of the most highly skilled nurses as well as those living in the city, if not more, owing to the distance from

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[228] In November, 1924 the CNA president wrote an answer to Dr. Eason of Britain who had criticized the report on nursing and nursing education in the USA:

> It is quite possible that the type of training Dr. Eason recommends would turn out good institutional machines, but I am wondering what would happen to the nurses who go out into the small towns and rural communities of Canada with this equipment. The nurse who had all initiative and resourcefulness trained out of her would find herself in a sorry plight when the nearest physician was anywhere from twenty-five to fifty miles distant.

(Browne, J. (1925). To the editor of "The World's Health". The Canadian Nurse, 21, pp. 83-84); Stewart, I. (1929). Professional school or trade school. The American Journal of Nursing, 29, pp. 1105-1110; Stewart, I. M. (1926). Report on nursing education in countries affiliated with the International Council of Nurses. The Canadian Nurse, 22, pp. 23-29, 43.

[229] Government of Alberta. (1920). Statutes of Alberta. Edmonton: Author.

[230] Editor. (March 1, 1920). The Legislature. Edmonton Bulletin, p. 2.

the home of the medical men in the vicinity." [231] In 1924, nurses at the annual convention ratified recommendations by a survey committee to expand the district or visiting nursing service rather than using trained attendants. It had been reported that five of six doctors in Northern Alberta preferred the services of a graduate nurse making daily visits and the general opinion of the public was, "They distinctly prefer the graduate nurse but cannot afford to pay her and suggest that she should work under some organization or public body." A letter concerning this decision was sent to the Provincial Council of Women. [232] The AARN and the UFWA recommended against "subsidiary nurses" in reports to the Minister of Health. Miss McPhedran was asked to outline the AARN's proposed nursing services scheme to the Provincial Council of Women. [233] It would appear the intervention of the AARN had an impact on the development of policy relating to trained attendants. Significantly, this action was in a policy area directly affecting the area of practice of the AARN.

Service Ideal and Code of Ethics

In much of the nursing literature in the 1920s the terms "service ideal" and "ethics" were used interchangeably. The

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[231] Editor. (1923). Alberta. The Canadian Nurse, 19, p. 110.

[232] AARN. (November 12, 1924). Minutes. Calgary, AB.

[233] AARN. (May 4, 1929). Minutes. pp. 241-242.

service ideal was still based on Christian values. [234] Florence Potts suggested four ways to promote ethics in training schools: (a) attending church, "The culture of the heart is as necessary as the culture of the mind, and the church is the source of this moral teaching"; (b) "cheerfully carrying out the discipline of the school", discipline decreased chaos, produced determination, confidence and self-respect; (c) role modeling of senior students and development of a "esprit de corps"; and (d) reading nursing journals. [235] Although, she titled her paper, Nursing Ethics, it would seem that she was discussing service ideal not a code of ethics. At the 1921 annual general meeting of the CNATN, Mary A. Catton recommended a written code of ethics be developed, however, nothing more was reported during the 1920s. [236] The development of a code of ethics may have been preempted by the demands of developing educational standards. This decision may also have been influenced by the fact the ANA code of ethics was

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[234] Editor. (1921). Report of the committee appointed by the Canadian National Association of Trained Nurses, on the possible establishment of student Christian activities in the training schools for nurses of Canada. The Canadian Nurse, 17, pp. 418-450. Editor. (1921). Annual meeting. The Canadian Nurse, 17, pp. 457-462. One of the recommendations was that the training schools be linked to the YWCA.

[235] Potts, F. J. (1921). Nursing ethics. The Canadian Nurse, 17, pp. 222-224.

[236] Catton, M. A. (1921). The question of a 'code of nursing ethics and etiquette' for Canadian nurses. The Canadian Nurse, 17, pp. 553-555.

being developed and the AARN was waiting to learn from their work. [237]

In the fourteen years that followed the proclamation of the Registered Nurses Act, the AARN made significant progress in advancing itself as a professional association. However the demands of organizing itself internally affected its ability to have very much impact on health care services and health policy. During this period advancements in health were largely the product of efforts of the government or other non-government agencies providing services.

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[237] Schulte, H. W. (1929). Professional ethics. The American Journal of Nursing, 29, pp. 410-414); Editor. (1928). Ethical problems. The American Journal of Nursing, 28, pp. 280, 404, 608; Johnson, P. E. (1928). What should ethic teach? The American Journal of Nursing, 28, pp. 1084-1089; Editor. (1926). A suggested code. The American Journal of Nursing, 26, p. 599.

# Chapter IV

## AARN in the 1930s: Surviving the Great Depression

External events of the 1930s had a critical effect on the development of the AARN. The Great Depression had a major impact on health care services and health policy, as well as on the nursing profession. The need for a response to the Weir Report dominated the activities of the Association. It was in this environment the AARN continued to focus on its development as a profession.

The Weir Report identified major areas of concern in nursing which included the poor working and living conditions of nurses and deficiencies in training schools and educational standards. Dr. Weir also expressed concern for the affordability and accessibility of nursing care for the public. The Great Depression had a direct effect on the employment level of nurses, as many members of the general public could no longer afford to hire nurses. All levels of government and members of the public expressed an increasing interest in the socialization of hospital care and nursing services. Many nurses still had not become registered with the AARN and a significant number of registered nurses were unemployed. This chapter examines the priority placed by the AARN on health care services and health policy in light of these many concerns.

In 1932 the long awaited survey of nursing education in Canada was completed. The study, conducted from November 1,

1929 to July 31, 1931, was comprehensive, [238] and made many useful recommendations. According to Dr. Weir the study was concerned with economic, educational, and sociological problems related to nursing. [239]

Following WWI there had been growth in the nursing area resulting in 18,174 registered nurses in Canada as of January 1, 1930. [240] Forty-two percent were inactive, thirty-five percent worked in private duty, fourteen percent worked in institutions,

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[238] Of the 205 training schools in Canada 145 were visited during the survey (Weir, G. M. (1932). Survey of nursing education in Canada. Toronto: UofT, p. 315). The survey included information from 437 representative patients and a cross-section of groups knowledgeable about the cost of health care to the public (Weir, G. M. (1932). Survey of nursing education in Canada. Toronto: UofT, pp. 406-416).

[239] (a) *Economic*--Dealing with...supply and demand; unemployment among nurses; fees and savings; distribution of nursing services; relative costs of staffing with only graduate nurses and of conducting a training school for student nurses....
(b) *Educational*--...preliminary education; admission requirements to training schools; examinations; varieties of training; methods of teaching; the minimum requirements in such matters of size of institution, equipment, teaching staff, clinical material...; methods of attaining more objective and reasonably uniform standards in such matters as curricula, involving also the controversial issues of theory and practice, and the reliability of the ordinary examinations.
(c) *Sociological*--The community needs regarding nursing services....Are people of moderate incomes getting the kind of nursing services they need? and...Are such services available at a reasonable cost? Furthermore, the interests of the nurses, who obviously is entitled to a respectable livelihood in return for services rendered, must also be considered.
(Weir, G. M. (1932). Survey of nursing education in Canada. Toronto: UofT, p. 15)

[240] *Ibid.*, pp. 55-56. These numbers excluded untrained, semi-trained, or trained but not registered people providing "nursing" care. In 1921, there was one nurse for 411 people and in 1930, there was one to every 327 people.

and eight percent worked in public health. One statement made by Dr. Weir would seem to accurately summarize the conditions under which many nurses worked:

> No other profession, not even the medical, has quite the same hours of labour--on day or night duty for twelve or twenty-four hours, for seven days in the week--until she may become the victim of utter exhaustion....The nurse on the frontiers must take risks and endure hardships even where no, or only fancied, emergencies exist....She is subject to dismissal by two masters, the physician and the patient....She also needs an abounding sense of humour as well as a sane humanitarianism. She must be 'tolerant even to the extent of tolerating intolerance' when no vital principle is at stake. [241]

He estimated the median yearly income of a private duty nurse as being $1022.00, so low as to leave many nurses on "the brink of economic disaster." [242] The median annual income of Canadians was reported as $2000.00. He recommended the eight hour day 'for institutional nurses with pay comparable to specialists in high schools. [243] He expressed his surprise that hospitals concerned with curing disease and promoting health would not apply the same philosophy to the living conditions of their nurses,

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[241] *Ibid.*, pp. 26-27.

[242] *Ibid.*, pp. 406-416, 467.

[243] *Ibid.*, p. 116.

the majority of whom lived in overcrowded residences, some little better than "fire traps." [244]

Perhaps one of the most revealing findings of the study was: "39 per cent. of the students examined had I.Q.'s of 95 and under--and require brains first before R.N. Diplomas are given." [245] He recommended intelligence testing of all candidates with less than four years of high school. However this was only one of the problems related to the education of nursing students. Other problems included: too few adequately prepared and experienced instructors, too few graduate nurses to provide supervision of practical work, too little classroom theory, too little time for lectures during the work day, and too little social and recreational time.

Dr. Weir stated that there was a need for training schools to change the emphasis from viewing a competent nurse as "a mere technician or machine" [246] to seeing a nurse as an "alert,

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[244] "Nurses should be housed, under hygienic and sanitary conditions, in residences separate from the hospital" (Weir, G. M. (1932). Survey of nursing education in Canada. Toronto: UofT, pp. 299-300).

[245] *Ibid.*, p. 218. Many countries were studying psychological testing of nursing students (Editor. (1932). Psychological tests in European schools of nursing. The International Nursing Review, 7, pp. 521-524; Potts, E. M. (1932). The use of psychological tests in school of nursing in the United States of America. The International Nursing Review, 7, p. 532; Brown, H. (1937). The value of psychological testing. The Canadian Nurse, 33, p. 333; Gabriel, J. (1931). The value of intelligence tests and high school records in selecting student nurses. The Canadian Nurse, 27, pp. 529-531).

[246] Dr. Weir continued to report that a portion of the medical profession and the laity was critical of the increasingly theoretical education of nurses, although he stated that many of the arguments

efficient, and cultured human being" [247] capable of responding to health problems because of the principles not the techniques learned. [248] Recommendations were made for the CNA to help provincial associations develop curriculum and set minimum standards for schools. [249]

Dr. Weir delineated three stages in the evolution of the nursing profession: (a) awareness of possibilities, but lack of cohesion necessary to form an effective organization; [250] (b) beginning of professional pride with increased self-consciousness and occasional "hypersensitiveness;" [251] and

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presented seemed to lack logic. He categorized the physicians into three groups: (a) reactionary who advocated traditional training of the nurse and no high school entrance requirement; (b) moderate who discouraged any change "without adequate testing and sufficient philosophical analysis," however, they judiciously supported higher entrance requirements and higher quality of theoretical education; and (c) progressive who advocated the need of an intelligent and educated nurse (Weir, G. M. (1932). Survey of nursing education in Canada. Toronto: UofT, pp. 29-31).

[247] *Ibid.*, p. 50. Seventy-three of seventy -five respondents stated, "leisure time for cultural and other improvement, 'was the' greatest deficiency" (p. 46). Dr. Weir insisted that it was the responsibility of superintendents of nurses and principals of training schools to ensure students' educational interests were protected and not "sacrificed to the economic needs of the hospitals" (p. 166).

[248] *Ibid.*, p. 51. The idea of problem-based learning rather than lectures was recommended frequently throughout the report (pp. 40, 50, 96, 141-142, 339). Dr. Weir provided extensive information on how to devise curricula, methods of teaching and learning, and testing.

[249] *Ibid.*, p. 300.

[250] *Ibid.*, p. 32. He suggested that this stage occurred prior to WWI .

[251] *Ibid.*, p. 32. By 1931 this stage was just being completed.

(c) critical analysis of the nursing profession and the external community. [252] He believed the nursing profession was just going to enter this third stage of its evolution. Its object would be to respond to the ever changing health needs and to the scientific specialization in preventive and curative medicine while cooperating with others in the community who were promoting health. Perhaps this was why he discussed to some length his ideas regarding state health insurance which he based on utilitarian theory: "State paternalism has a traditional and almost sinister suggestiveness; but in its best sense--that of guaranteeing a square deal in matters of health to the humblest and poorest member of the political family--this expression probably best sums up the rapidly growing spirit of the age." [253]

Even though the report did not make recommendations related to medical services and focused primarily on socialization of nursing services and hospital care, Weir acknowledged an awareness that, "There exists a strong antipathy, sometimes based on prejudice rather than on logical thinking or on a knowledge of the facts of the health situation, to any plan that is suggestive of socialized nursing or any aspect of

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[252] *Ibid.*, p. 33. "The nursing profession....rightly lays claim to professional autonomy...loyal associate of all kindred professionals, but...servitor of none.

[253] *Ibid.*, p. 415.

so-called 'state medicine' as a substitute for the present individualistic and largely competitive system." [254]

The Weir report provided the CNA and AARN with a great deal of information to analyze and upon which to act. [255] In 1932, the CNA began to research the cost of nursing education [256] and the distribution of nursing services [257] prior to implementing some of the recommendations made in the Weir report. The following resolutions came out of the CNA's analysis of the Weir report: (a) that hospital boards be asked to reduce the number of students used as personnel and increase the number of graduate nurses, [258]

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[254] *Ibid.*, p. 497.

[255] Non-nurses wrote about their impressions of the Weir report (Fraser, R. (1932). The scientist and the survey report. The Canadian Nurse, 28, pp. 423-432; Massey, V. (1932). The public and the survey. The Canadian Nurse, 28, pp. 459-466).

[256] Gunn, J. I. (1932). An analysis of the cost of nursing education. The Canadian Nurse, 28, pp. 579-585; McKee, M. (1932). The cost of the student nurse to the hospital. The Canadian Nurse, 28, pp. 585-588; Fairley, G. M. (1932). The comparative cost of the student and the graduate nurse. The Canadian Nurse, 28, pp. 589-590; Hersey, M. F. (1932). The budget system. The Canadian Nurse, 28, pp. 591-593. By 1934, twenty-four nursing schools had closed in Canada of the 193 left 180 were approved schools of nursing. There were 8,263 nursing students (Editor. (1936). Nursing education in Canada. The Canadian Hospital, 13(5), pp. 17-20).

[257] The Weir report had stated that two-thirds of all nurses were in 25 cities in Canada which resulted in poor coverage of rural areas (Browne, J. E. (1932). The distribution of nursing services. The Canadian Nurse, 28, pp. 635-639; Ellis, K. W. (1932). Supply and demand. The Canadian Nurse, 28, pp. 640-642; McPhedran, E. (1932). Socialized nursing. The Canadian Nurse, 28, pp. 643-646; MacMaster, A. J. (1932). Dominion bureau of nursing, provincial boards of control, district registries. The Canadian Nurse, 28, pp. 646-649).

[258] The author was superintendent of Norfolk General Hospital, Simcoe, Ontario (Buck, M. (1933). Staffing the hospital with graduate

(b) that study committees examine superannuation plans for nurses, (c) that provincial associations lobby for socialization of nursing services, (d) that a National Joint Study Committee examine the idea of a Dominion Bureau of Nursing and report recommendations to the CNA, and (e) that provincial associations lobby for compulsory licensing of people giving nursing care. [259] The AARN was an active member of the CNA. Its Minutes regularly included reports from the delegates or from the CNA directly as to the commencement of these initiatives and their progress.

## Socialization of Health Care Services

Dr. Weir had urged a radical reorganization of nursing services if services were to be made available to all patients, not only the indigent. He proposed, "Socialization of nursing services, with adequate distribution of the financial burden through a form of state health insurance." [260] The CNA and AARN saw health insurance and socialization of nursing as the way to ensure

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nurses. The Canadian Nurse, 29, pp. 347-349); This author was superintendent of The Galt Hospital, Galt, Ontario (Cleaver, A. (1933). Transition to graduate nursing service. The Canadian Nurse, 29, pp. 352-354); Holt, M. (1936). Staffing with graduate nurses. The Canadian Nurse, 32, p. 5.

[259] Editor. (1932). The distribution of nursing services. The Canadian Nurse, 28, p. 650.

[260] Weir, G. M. (1932). Survey of nursing education in Canada. Toronto: UofT, p. 499. Chapters 24 and 25 discussed in depth changes necessary for socialized health care (pp. 474-534). He also saw the socialization of nursing as a way to ensure a living wage and better working conditions for nurses.

adequate nursing care to all people in Canada and to improve the living and working conditions of nurses. [261] During this period, as a result of the economic and social depression, unemployment was a serious problem facing nurses across Canada. [262] It was recorded in the Minutes of the AARN that between one half and two thirds of all private duty nurses had "unoccupied" time. [263] It was not surprising that socialization of nursing and hospital insurance were such palatable solutions to the public and most health professionals, as one of the major political and social movements sweeping the country at this time was the revived social gospel movement. [264]

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[261] McIntosh, J. W. (1930). Health insurance. The Canadian Nurse, 26, pp. 289-294; Fleming, G. (1933). The socialization of medicine. The Canadian Nurse, 29, pp. 117--122; Johns, E. (1930). A sense of values. The Canadian Nurse, 26, pp. 483-484, 501; "*The average household cannot afford to pay for the nursing service it needs*. Something had [sic] to be done to bridge this economic gap. Why not health insurance?" (Buhler, H. M. (1935). Can it be done? The Canadian Nurse, 31, p. 74).

[262] Ellis, K. W. (1933). Reductions or deficits. The Canadian Nurse, 29, pp. 173-175; Rowan, G. (1933). The crisis in private nursing. The Canadian Nurse, 29, pp. 645-647; Dewey, F. (1935). The eight-hour day. The Canadian Nurse, 31, pp. 216-218.

[263] AARN. (November 13-14, 1930). Minutes. Calgary, no page number. A suggestion to decrease the daily fee of $5.00 was not passed as it was thought that the patients that could not afford this would not be able to pay anything else and that any decrease would only put the nurse in a worse financial condition (AARN. (March 22-23, 1932). Minutes. Edmonton, p. 297; AARN. (October 10-12, 1933). Minutes. Calgary, p. 332).

[264] In the 1920s and 1930s social gospel movement became a major movement in the Protestant and Catholic churches (Marsh, J. H. (Ed.). (1985). The Canadian encyclopedia. Edmonton: Hurtig, pp. 342; Hutchinson, R. The Canadian social gospel in the context of Christian social ethics. In B. Hodgins & R. Page (Eds.), Canadian history since confederation (497-511). Georgetown, Ont: Irwin-Dorsey).

In November 1932, a committee of MLAs met to study and make recommendations concerning a way to finance and provide medical and health services to all Albertans. [265] The Commission on Health Insurance and State Medicine sought advice from a number of stakeholders; both the AMA and the AARN [266] presented briefs. Unfortunately, no record of this AARN brief was located, although Eleanor McPhedran asked that all the information be given to the registrar for safe keeping. [267] The Commission developed the following ten principles: (a) patient has the right of choice regarding physician, (b) physicians to receive fee for service, (c) all people with minimum income to receive coverage, (d) physicians to be provided with incentives to keep their knowledge and skill current, (e) no compensation for time lost through illness, (f) precautions to avoid abuse by patients, (g) preventive medicine to be a prominent part of the plan, (h) family physician primary to plan with specialist as secondary, (i) adequate hospitals to be provided throughout Alberta, and

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[265] Learmonth, G. E. (1932). Alberta. The Canadian Medical Association Journal, 27, p. 685.

[266] AARN. (1932). Annual report. Edmonton: Author, p. 7. George Hoadley, Minister of Health invited the AARN. Representatives appointed were Fanny Munroe, Ethel Fenwick, and Kate Brighty.

[267] AARN. (December 3, 1932). Minutes. Edmonton, p. 319.

(j) plan contributory and compulsory. [268] The plan was tabled for further consideration by the government. With the need for cutbacks in the existing health care system a new and costly program was not economically feasible at that time. [269]

In November of 1934, in response to a request from the CNA president, Ruby Simpson, the AARN updated the 1932 brief on health insurance and submitted it to the CNA and the Commission for consideration at the next Alberta legislative session. In this pro-active move the AARN also provided written assurances that the AARN would be able to provide all the nursing services required in a revised health care service arrangement. [270]

As governments focused more attention on the socialization of nursing and hospital care, the AARN continued its efforts to have input in the discussion. At the Provincial Ministers of Health Conference on Health Insurance in Ottawa in 1935 the observers from the CNA were present. The AARN sent a night

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[268] Learmonth, G. E. (1933). Alberta. The Canadian Medical Association Journal, 28, p. 110.

[269] In 1932, the Alberta Federation of Labor asked Mr. Hoadley for free clinics for indigents within Calgary similar to the travelling clinics. When asked for their recommendations The Calgary Medical Society declared, "They were not in favour of the free clinics" (Learmonth, G. E. (1932). Alberta. The Canadian Medical Association Journal, 26, p. 124). To save $30,000.00 travelling clinics were cancelled in 1932 (Learmonth, G. E. (1932). Alberta. The Canadian Medical Association Journal, 26, p. 636). In 1937, they were reinstated to provide services only in areas without medical practitioners (Learmonth, G. E. (1937). Alberta. The Canadian Medical Association Journal, 36, 660).

[270] AARN. (November 12, 1934). Minutes. Edmonton, p. 369.

letter to the Alberta Health Minister who was participating in the Conference. [271] The Alberta Health Insurance Act was passed in 1935. Miss Munroe was commended by the council for her efforts to ensure nursing services were included in the health insurance bill that had just passed in Alberta. [272] Before the act could be implemented the UFA were defeated by the Social Credit who had another health plan in mind for Alberta. [273] With no immediate prospect for federally or provincially funded health insurance programs, the UofA hospital began its own group hospitalization. [274]

In 1937 the CNA submitted a brief to the Royal Commission on Dominion-Provincial Relations. The CNA recommended: (a) a

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[271] AARN. (May 14, 1935). Minutes. Edmonton, p. 379. The CNA had initiated the idea. Jean Wilson, Jean Gunn, and Elizabeth Smellie were among the observers representing health, labour, finance and insurance interests at this Conference held April 25-26, 1935. They reported that a Royal Commission was to be set up to look into Canada's health services (Wilson, J. S. (1935). Notes from the national office. The Canadian Nurse, 31, p. 269).

[272] AARN. (May 14, 1935). Minutes. Edmonton, p. 379. The provincial commission that was to inaugurate the insurance scheme included: George Hoadley, Minister of Health of Edmonton; Dr. A. E. Archer, Lamont; and Dr. M. R. Bow, Deputy Minister of Health, Edmonton (Fleming, G. (1935). The Alberta health insurance act, 1935. The Canadian Medical Association Journal, 33, 87).

[273] The medical profession did not lose its voice as Dr. W. W. Cross was made Minister of Health, the first medical practitioner to occupy this position (Learmonth, G. E. (1935). Alberta. The Canadian Medical Association Journal, 33, p. 459; Learmonth, G. E. (1937). Alberta. The Canadian Medical Association Journal, 36, p. 100).

[274] Editor. (1937). Group hospitalization. Alberta Medical Bulletin, 2(8), pp. 4-5.

comprehensive survey of health services in Canada be conducted; (b) if health insurance provided for medical services it should include nursing services; (c) prevention be a prime focus and included under health insurance; (d) nursing be included on any advisory council involved in the administration of nursing services that fall under health insurance; and (e) nursing be consulted when regulations are drafted that affect nursing services. [275]

## The Great Depression

The 1930s were often referred to as the "dirty thirties" in the prairie provinces, which not only suffered economic depression like the rest of Canada, but also suffered through a number of droughts and crop failures that took away the very little security left to the people, that of being able to feed themselves. [276] The municipal and provincial governments were not able to provide all the relief necessary for the vastly increased population. [277] Continuing help had to be requested from the Canadian government which had been cost sharing some basic relief programs throughout the 1920s. This assistance

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[275] CNA. (1938). A submission to the Royal Commission on Dominion-Provincial Relations. The Canadian Nurse, 34, pp. 371-374.

[276] McNaught, K. (1970). The history of Canada. Toronto: Bellhaven.

[277] McInnis, E. (1982). Canada: A political and social history. Toronto: Holt, Rinehart & Winston, p. 504. He wrote, "In the decade ending in 1931...Alberta's [population] grew by more than 140,000....occupied land...increased by...one-third." Careless supported this information ((1970). Canada a story of challenge. Toronto: Macmillan).

changed the balance of power from the province to the federal government in the area of health care services and health policy. McInnis noted:

> The broad interpretation given to...control over 'property and civil rights' virtually barred the Dominion from the whole field of social policy.... Provinces lacked the financial resources...and action on a purely provincial basis made it difficult to achieve the uniform national level...in such fields as labor standards and health services. Thus the federal government...was forced to find other ways....By providing federal grants-in-aid....it was sometimes possible to make these contingent on the adoption of standards laid down by the Dominion. [278]

The depressions of the 1920s and 1930s stimulated action, not only by the Canadian and Alberta governments, but also by volunteer organizations to meet the overwhelming needs of the population. [279]

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[278] McInnis, E. (1982). Canada: A political and social history. Toronto: Holt, Rinehart & Winston, p. 509. Other authors concurred with McInnis (Porter, J. (1979). The Canadian political system. In B. Hodgins & R. Page (Eds.), Canadian history since confederation.(590-602). Georgetown, Ont: Irwin-Dorsey, p. 600; Creighton, D. (1970). Canada's first century (1867-1967). Toronto: Macmillan, pp. 207-208). Parliament assented to The Relief Act on May 13th, 1932 which empowered the Federal government to take any economic measures it deemed necessary in assisting the provinces. This act was passed again in 1933, 1934, 1935, and 1936 (Dominion of Canada. (1932). Statutes of Canada. Ottawa: Author, p. 99). The Unemployment and Farm Relief Act allowed for a 50% cost share of all direct relief (Dominion of Canada. (1936). Statutes of Canada. Ottawa: Author, p. 343; Government of Alberta. (1932). Statutes of Alberta. Edmonton: Author, pp. 63-68, 157-158). As the transient population was often excluded from relief programs The Bureau of Public Welfare Act-1939 was passed to provide material aid to destitute transient persons (Government of Alberta. (1936). Statutes of Alberta. Edmonton: Author, pp. 25-35).

[279] The Canadian Red Cross Society took many new initiatives in health programing and medical research in areas such as tuberculosis,

With one quarter of the Canadian work force, approximately 826,000 people, out of work and seeking employment, [280] it was not surprising that the economic depression also affected the McGill School for graduate nurses. The AARN affirmed its commitment to improving nursing education when it sent two hundred dollars to help ensure the continuation of the McGill program. [281]

The AARN showed its concern for its membership by decreasing the 1933 annual fees to $2.00 and setting up a loan fund. [282] The Lethbridge Association of Graduate Nurses set up a relief fund for unemployed nurses which they maintained through

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venereal disease, mental health, child welfare, blindness, diabetes, and dental hygiene. Its mandate was to fill gaps and not to overlap or duplicate services, to work cooperatively with governments and other agencies to ensure good public health programming to all Canadians. It provided supplies and financial assistance to some municipal hospitals and established hospitals where there was not an adequate tax base to provide municipal hospitals (Canadian Red Cross Society. (1962). The role of one voluntary organization in Canada's health services. Toronto: Author, pp. iv, 16-17, 68-72; Claxton, M. (1933). Pioneering in the Peace. The Canadian Nurse, 29, pp. 537-538).

[280] Creighton, D. (1970). Canada's first century (1867-1967). Toronto: Macmillan, p. 206.

[281] Editor. (1933). The crisis in education. The Canadian Nurse, 29, pp. 249-250; AARN. (March 4, 1933). Minutes. Calgary.

[282] AARN. (1932). Annual report. Edmonton: Author, pp. 7-8. From the statistics kept, it would appear that a number of nurses dropped their registration because of the inability to pay between 1928 and 1933. The loan fund was primarily contributed to by institutional, public health and VON nurses on salary, although it was reported that a few private duty nurses also contributed. Few calls were made upon this loan fund in 1932 and 1933 (AARN (March 22-23, 1932). Minutes. Edmonton, p. 298; AARN. (October 10-12, 1933). Minutes. Calgary, p. 230).

local activities such as teas and rummage sales. The Edmonton branch of the private duty committee attempted to encourage hourly and part-time home nursing; however this proved unsuccessful. Its failure was partially attributed to the fact the VON was doing this type of work. [283]

In 1933 to improve health care and provide employment for a nurse, the AARN proposed to finance a district nurse in an area where nursing was "urgently" needed. [284] More innovative approaches to relieve nursing unemployment were proposed in 1934: (a) the Calgary Group Nursing Society [Society] presented a scheme which offered nursing services for a monthly premium of one dollar for a family and fifty cents for an individual, [285]

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[283] AARN. (March 22-23, 1932). Minutes. Edmonton, p. 297.

[284] AARN. (December 9, 1933). Minutes. Edmonton, p. 346. The education and employment project nurse was trained and supervised by the Provincial District Nurse. Alder Flats was chosen by the Deputy Minister of public health (AARN. (May 23, 1934). Minutes. Edmonton, p. 350); Marjorie Maynes was hired at the monthly salary of $50.00 plus expenses (AARN. (October 10, 1934). Minutes. Edmonton, p. 365; Brighty K. S. (1935). An experiment in rural nursing. The Canadian Nurse, 31, pp. 501-502; Maynes, M. (1935). Alder Flats. The Canadian Nurse, 31, pp. 503-504); Jean McKinnley was hired (AARN. (May 14, 1935). Minutes. Edmonton, pp. 378-379). Continuation of the program was approved (AARN. (June 22, 1936). Minutes. Calgary). The program was discontinued in 1937 (AARN. (May 29, 1937). Minutes. Edmonton).

[285] Editor. (1934). The Calgary experiment. The Canadian Nurse, 30, pp. 516-517; AARN (September 8, 1934). Minutes. Calgary, p. 355.

(b) the AARN investigated setting up a registry and (c) the AARN proposed to examine placing some of the sixty-three public health nurses on monthly salaries. [286]

In 1935, the AARN once again attempted to ease the plight of its members: (a) a committee was appointed to form a Central Registry for Alberta, [287] (b) a nurse who had let her registration lapse could be reinstated in good standing by paying a fifteen dollar registration fee, [288] (c) two discussion questions suggested by the AARN for discussion at the AHA conference were meant to increase awareness of nursing issues: "Is the AHA aware of the Provincial Nursing Bureau?" and "Would you be good enough to discuss...Graduate nurses working in hospitals 12 to 16 hours seven days a week, for $15.00 to $25.00 a month?" [289]

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[286] AARN. (October 10, 1934). Minutes. Edmonton, pp. 357-362. The registry was discussed frequently throughout the 1930s, however, there was no further mention of placing public health nurses on salary.

[287] Although local registries were to report to the central registry, they were given much autonomy in relation to: scope of work, supervision of registrants, and fees (AARN. (January 26, 1935). Minutes. Calgary, p. 372).

[288] AARN. (March 23, 1935). Minutes. Miss Munroe's sitting room, Edmonton, p. 376. Arrears equal or more than $15.00 would be erased with the $15.00 payment.

[289] AARN. (November 9, 1935). Minutes. Edmonton, p. 385. The AARN passed a motion from the private duty section recommending that hospitals and registries be asked to introduce eight hour shifts (AARN. (November 15-17, 1937). Minutes. Edmonton, p. 434). By March, 1935, the Royal Alexandra and UofA hospitals had established an eight-hour duty system for private duty nurses (Editor. (1935). News notes: Alberta. The Canadian Nurse, 31, p. 125).

## Nursing Educational Standards

The priority of the CNA and the AARN throughout the 1930s was to work toward improvements in the art and science of nursing: (a) a CNA committee presented to the membership a proposed standard curriculum for Canadian schools of nursing, [290] (b) the AARN was involved in inspection tours of training schools, and (c) the AARN was involved in conducting continuing education programs for graduate nurses. [291]

A CNA committee, chaired by Marion Lindeburgh, after five years of research and consultation with the provincial associations presented a proposed standard curriculum to the biennial convention in Vancouver in June, 1936. [292] The AARN approved the use of this curriculum for Alberta's schools of

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[290] Many articles discussed a standardized curriculum (Chauvin, M. A. (1931). Correlation in teaching the student nurse. The Canadian Nurse, 27, pp. 22-23; Fairly, G. M. (1931). A curriculum for schools of nursing in Canada. The Canadian Nurse, 27, pp. 476-479, 531-532, 586-587, 637-639; Editorial: Comment on successful curriculum for schools of nursing. The Canadian Nurse, 27, pp. 479-480, 533-535, 587-589, 639-641, 648). The revised curriculum was sent to schools to use as a guide until the UofA could approve it (AARN. (September 8, 1939). Minutes. Calgary, p. 494).

[291] Refresher courses were well attended in Alberta in the 1930s. Some supervisors recognized their responsibility to provide educational opportunities (i.e., libraries, conferences, newsletters) (Brighty, K. S. (1937). Staff education in public health nursing. Canadian Public Health Journal, 28, pp. 182-184; Robertson, I. (1936). Professional growth and staff education. The American Journal of Nursing, 36, pp. 1023-1026).

[292] Editor. (1936). The proposed curriculum for schools of nursing of the Canadian Nurses' Association. The Canadian Hospital, 13(9), p. 21.

nursing and passed the following resolution at their annual meeting in 1938:

> Whereas the cooperation of Boards of Directors of the Training Schools is essential for the advancement of Nursing Education, and Whereas the Boards of Directors are ultimately responsible for the financing of Nursing Education projects, Be it Resolved therefore: That the Committee for the Inspection of Schools of Nursing in Alberta be requested by the A.A.R.N. to meet within the ensuing year the Boards of Directors or representatives of these Boards and Medical Superintendents of the Training Schools in Alberta, and discuss with them the importance and necessity of making provision for putting into effect the principles of education as suggested in the "Proposed curriculum for the Schools of Nursing in Canada. [293]

The AARN approved a resolution that inspection of nursing training schools should be made by qualified graduate registered nurses. [294] This resolution was probably in response to a report from Eleanor McPhedran to the convention. In 1931, Eleanor McPhedran, Dr. J. J. Ower, professor of pathology UofA, and Mr. A. E. Ottewell, registrar of the UofA, were appointed by the UofA senate to an inspection committee. Eleanor McPhedran reported results of the inspection to the 18th annual AARN convention: (a) two part-time and one full-time schools (Camrose) were closed; (b) Vegreville had until January 1935 to meet the standards; (c) St. Michael's in Lethbridge agreed to wait before

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[293] AARN. (October 6-7, 1938). Minutes. Calgary, p. 457.

[294] AARN. (October 10-12, 1933). Minutes. Calgary, p. 230. The UofA senate was asked to change the wording of the Registered Nursing Act to reflect this resolution.

establishing a school of nursing; (d) seven of the other hospitals (four in Edmonton, two in Calgary, one in Lamont and one in Medicine Hat) had increased the entrance requirement to Grade XI; and (e) care and supervision of the health of the students had improved in some hospitals, however, not in all. [295] Inspection tours continued throughout the decade. The Minutes of the AARN contained a report from a fourth inspection tour in September 1938. The committee made the following observations which reflected many of the same concerns identified by the CNA in 1932 and earlier committees: (a) there were too many schools, (b) science courses were not well taught, (c) none of the schools had completely adequate classroom facilities, (d) the teaching load of the instructors was too heavy, (e) teaching on the wards was not adequately arranged, and (f) most schools did not have enough qualified instructors. From these observations the committee recommended that there be a repeat inspection in 1939 with an increased emphasis on meeting with management of the schools, and that Vegreville continue its training school for two years when a reassessment will be made. [296] The committee emphasized that student education must be the objective of the nursing schools and provided some guidelines to follow for

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[295] *Ibid.*, pp. 334-335.

[296] AARN. (April 11-12, 1939). Minutes. Edmonton, pp. 487-490.

institutional and educational staff, ward arrangements, student living facilities and student educational facilities. [297]

In 1937 the AARN discussed the permanent appointment of a qualified school advisor. Her duties would be to help schools prepare for the yearly inspection by making suggestions for improvements and explaining regulations in hope of providing more uniform standards. [298] Initially the AARN approached the Saskatchewan Registered Nurses Association [SRNA] to discuss sharing their school advisor, K. Ellis. The SRNA did not agree to this plan for sharing Miss Ellis; therefore, the AARN decided to conduct a one year trial which included paying expenses plus an honorarium to Agnes McLeod to do a survey of the nursing schools in Alberta. [299] Agnes McLeod was to continue on as a yearly appointment, concentrating more of her time in the classroom in order to help improve teaching skills. [300]

On September 10th, 1939 Canada, as an independent nation, declared war on Germany. [301] The Canadian Nurse utilized a

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[297] *Ibid.*, pp. 487-490.

[298] AARN. (March 13, 1936). Minutes. Edmonton, p. 394; AARN. (November 15-17, 1937). Minutes. Edmonton, p. 434.

[299] AARN. (February 19, 1938). Minutes. Edmonton, pp. 441-442.

[300] AARN. (November 26, 1938). Minutes. Calgary, p. 459.

[301] McInnis, E. (1982). Canada: A political and social history. Toronto: Holt, Rinehart & Winston, p. 557; Marsh, J. H. (Ed.). (1985). The Canadian encyclopedia. Edmonton: Hurtig, pp. 1975-1976. Britain and France declared war on Germany on September 1, 1939. The CMA made a

picture of a statuette of "The Lady with the Lamp," with a message of "guarding the flame" to convey its calm commitment to service. [302] The message from Grace Fairley conveyed with few words the shock of another war and the expectation that nurses would once again provide their necessary services at home and overseas. [303]

There was a tangible shift in the activity of the AARN during the 1930s. As Dr. Weir observed, it was moving from an internal focus to taking an increasing interest in the critical analysis of the nursing profession and the external community.

## Health Care Services and Health Policy

In 1936 Dr. G.Fleming defined health as a holistic concept:

> Health is that condition which we enjoy when all parts of the body are functioning harmoniously. Personal health is not purchasable with money; it is based upon the habits of life of the individual. It is what we eat and how we eat it,

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statement that they would be willing to act in an advisory capacity to the Government of Canada to ensure adequate medical care of both the armed forces and the rest of the Canadian population (Routley, T. C. (1939). War. The Canadian Medical Association Journal, 41, p. 390).

[302] Editor. (1939). Guarding the flame. The Canadian Nurse, 35, pp. 560, 562-563.

[303] Fairley, G. M. (1939). A national emergency and national service. The Canadian Nurse, 35, p. 561.

> The Canadian Nurses Association will follow the paths of its members with deep interest and affection, knowing that whatever duty lies ahead they will do it. Words are so inadequate in times like these that one can do no better than quote again from the King's address to his people: 'I ask them to stand calm and firm and united in this time of trial...and reverently commit our cause to God. May He bless and keep us all'.

> the amount of rest, fresh air, and exercise which we enjoy, our capacity to meet, in a self-satisfying manner, the day-by-day problems of living which decide what measure of physical and mental health shall be ours....
>
> Health is desirable, not as an end in life but as a means to an end--that of increasing human happiness through a more nearly complete development of the efficiency and effectiveness of the individual. The Individual is a functioning unit, and health represents a fitness of both the physical and the mental aspects of this unity. The two cannot be separated; both must be dealt with together, since man is not merely a wonderfully complicated *physical* machine. [304]

Although the trend was moving toward increased hospitalization in the 1930s, the scientific and technological advances in medical treatments and pharmaceuticals were only beginning. Prevention, [305] particularly in the area of health education, was still viewed by many as critical to health status of Canadians. [306]

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[304] Fleming, A. G. (1936). Givers of life. The Canadian Medical Association Journal, 34, pp. 198-199. Dr. Fleming was professor of public health and preventive medicine at McGill University. "A fair criticism of health insurance is that it has not been preventive in practice and but little in outlook. It is not enough to render lip service to the idea of the practice of preventive medicine by the general practitioner, and then to disregard him in planning public health services" ((1932). The relationship of public health to medical care. Canadian Public Health Journal, 25, p. 461).

[305] "Health is today recognized as man's greatest asset, and no one will dispute that preventive medicine plays an important part in its attainment" (Editor. (1931). Do we understand. The Canadian Nurse, 27, pp. 139-143).

[306] In 1930, Dr. A. Grant Fleming wrote that publications were not enough, but that physicians had to become health teachers (Fleming, A. G. (1930). Education of the public in health matters. The Canadian Medical Association Journal, 22, p. 562). In 1932, Dr. Weir stated that health education and preventive programming was more cost effective than caring for the ill ((1932). Survey of nursing education in Canada. Toronto: UofT, p. 49).

With widespread poverty the health status of the people was deteriorating. [307] Part of the problem was due to poor nutrition, consequently it became an increasingly important focus in nursing education [308] and in public education. [309] Research began in the late 1930s on the nutritional status of Canadians and ways

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> We have reached the stage now when the lives of people are well protected through the provision of pure water, milk and food, through child welfare, through sanitary disposal of human wastes, and through better control of preventable diseases. Progress in the future should take place by teaching individuals to protect themselves, by showing where danger lies and how to avoid it, by trying to make every person a health officer for himself and his family.

(Douglas, A. J. (1930). Ways and means in public health. Canadian Public Health Journal, 21, p. 264) Dr. Douglas was medical health officer of Winnipeg and president of the CPHA.

[307] Canada's infant mortality rate for 1935 (71/1000) more than double that of New Zealand (Editor. (1943). Infant mortality rates. Alberta Medical Bulletin, 8(3), p. 30; Cosbie, W. G. (1940). Maternal mortality. The Canadian Medical Association Journal, 43, pp. 38-44). Dr. Fleming stated in 1930 that there were two chronic communicable diseases in Canada, tuberculosis and syphilis (Fleming, A. G. (1930). The general practitioner in public health. The Canadian Medical Association Journal, 22, p. 43). In 1931, the life expectancy of a boy born in Canada was 60 years and of a girl was 62 years (Keyfitz, N. (1938). Canadian life tables, 1931. Canadian Public Health Journal, 29, pp. 587-590). It was reported that 20 communities in Alberta were without a medical practitioner in 1936 (Editor. (1937). Alberta register. Alberta Medical Bulletin, 2(9), p. 3).

[308] Malone, M. M. (1930). Diet in relation to medical conditions. The Canadian Nurse, 26, pp. 239-242; Kenny, Sr. (1932). The relation of the dietary department to the hospital. The Canadian Nurse, 28, p. 63; Penhale, M. N. (1936). Dietary treatment of diabetes. The Canadian Nurse, 32, p. 395.

[309] Bell, M. (1932). The nutritionist and the home. The Canadian Nurse, 28, pp. 596-598; Chambers, R. (1935). Minimum adequate food supply. The Canadian Nurse, 31, pp. 451-452; Editor. (1939). Our daily bread. The Canadian Nurse, 35, pp. 369-370; Harlow, M. (1939). Nutrition in the health mosaic. The Canadian Nurse, 35, pp. 370-373; Emerson, B. (1930). Child welfare. The Canadian Nurse, 26, pp. 199-201.

to improve health through better nutrition. [310] Another outcome of the depression may have been the high loss of life through violence, [311] suicide, [312] and accidents. [313] In 1937 in response to these health issues the Canadian government decided to strengthen the National Health Division of the Department of Pensions and National Health by adding on divisions to deal with: (a) publicity and health education, (b) maternal and child welfare, (c) industrial hygiene, and (d) epidemiology. [314] In 1938,

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[310] Stewart, A., & Porter, W. D. (1938). Food purchases by families in Edmonton and Lacombe, Alberta. Canadian Public Health Journal, 29, pp. 58-66; Sandin, M., Patrick, M., & Stewart, A. Food consumption of twenty-nine families in Edmonton, Alberta. Canadian Public Health Journal, 30, pp. 177-183.

[311] Alberta reported 372 violent deaths (Editor. (1939). Department of public health report for 1937. Alberta Medical Bulletin, 4(3), pp. 12-13).

[312] Alberta reported 101 suicides (Editor. (1939). Department of public health report for 1937. Alberta Medical Bulletin, 4(3), pp. 12-13). The high number of suicides in the world and Canada led to a study by a female physician for her Doctorate of Philosophy (Franks, R. M. (1937). The pathogenesis and prevention of suicide. The Canadian Medical Association Journal, 36, 139).

[313] In 1936, an annual driver's license was established and the government was considering setting up a fund for medical care of accident victims. Seventy-one deaths were attributed to automobile accidents in Alberta (Editor. (1937). Motor car accidents. Alberta Medical Bulletin, 2(7), p. 10).

[314] Editor. (1937). The federal government and public health. Canadian Public Health Journal, 28, pp. 344-345. By the beginning of WW II the bureaucracy of the Federal Department of Pensions and National Health had expanded greatly. The health section now had national and international activities and was divided into fifteen divisions: (a) consultant hospital construction and services; (b) public health engineering; (c) medical investigation; (d) proprietary or patent medicines; (e) narcotic drugs; (f) food and drugs; (g) laboratory of hygiene; (h) epidemiology; (i) child and maternal hygiene; (j) industrial hygiene;

the Canadian government created a Council on Nutrition to survey the country. Poverty and lack of nutritional knowledge were identified as the major problems. [315]

In 1930 the Alberta government made early efforts to respond to the health issues facing its population. The AARN president reported that the government had established two new districts for district nursing, appointed a nurse inspector for private hospitals and baby shelters, and established the first two health units. [316] In 1937, The Public Health Act was amended to provide for full time health districts and district boards of health to enforce the act. [317] By the end of the decade three other

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(k) publicity and health education; (l) quarantine, immigration, marine, leprosy; (m) purchasing agents; (n) architects and engineers; and (o) personnel (Heagerty, J. J. (1939). The activities of the national health section. Canadian Public Health Journal, 30, pp. 120-123). This journal contained reports on each of the divisions by the division chief (pp. 123-155).

[315] Editor. (1937). Nutrition: A national problem. Canadian Public Health Journal, 30, p. 60.

[316] AARN. (November 13-14, 1930). Minutes. Calgary, p. 262. The Department of Health budget for the 1931-1932 fiscal year reached $1,600,000.00 (Editor. (1930). Alberta. The Canadian Medical Association Journal, 24, p. 747). The health units were set up by Dr. W. G. Saunders in High River and by Dr. G. M. Little in Red Deer. Each unit had a three year budget of $30,000.00 (50% paid by the provincial government, 25% by the Rockefeller Foundation and 25% by the district). The staff included two nurses, a doctor, stenographer, and part-time sanitary engineer (Learmonth, G. E. (1932). Alberta. The Canadian Medical Association Journal, 27, p. 217).

[317] Government of Alberta. (1942). Revised Statutes of Alberta. Edmonton: Author, pp. 2231-2240.

health units had been established. [318] The Minutes of the AARN do not reveal any discussion of these changes to health care services and health policy regarding health units.

Dr. G. Stewart Cameron in his foreword to the Weir report, stated changes in nursing were due to "the vast strides that have taken place in the science and practice of medicine" and he discussed the increasing trend toward hospitalization of the acutely ill and therefore the need for more and better trained nurses working in hospitals. [319] To meet the consumer demand for access to adequate health care services in Alberta by 1929, there were eighty-seven approved hospitals with a total of 3,112 beds. By 1937, Dr. H. Agnew was recommending that administrators have a university degree in hospital administration: "The day

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[318] Learmonth, G. E. (1938). Alberta. The Canadian Medical Association Journal, 38, p. 619; Learmonth, G. E. (1938). Alberta. The Canadian Medical Association Journal, 39, p. 409; Learmonth, G. E. (1939). Alberta. The Canadian Medical Association Journal, 41, p. 316. Programming involved public health education, physical examination of all school children and many rural preschool children, control of communicable diseases, and food and sanitation control (Little, G. M. (1934). A full-time rural health district. Canadian Public Health Journal, 25, pp. 225-228).

[319] Weir, (1932), p. 165. Dr. Weir stated medical evidence indicated hospitals should be doing at least 50% more of the nursing care. In addition, he suggested studies be conducted to determine the feasibility of hospitals assuming total responsibility for the nursing care of average income patients. He recommended reducing student nurses by 50% and increasing graduate nurses by 28% of the student numbers.

In Canada in 1933, there were 876 hospitals with a total of 58,822 beds. 5,643 graduate nurses worked in staff positions in these hospitals. There were 220 approved schools of nursing with a total of 8,044 student nurses. The average patient stay was 14.6 days for general patients (Editor. (1936). Hospital statistics for Canada. The Canadian Medical Association Journal, 34, p. 454).

when any person--nurse, doctor, clergymen or accountant--could lightly assume the role of hospital superintendent would seem to be fast drawing to a close." [320]

Medical practitioners like nurses were affected greatly by the economic depression. [321] They were involved in two battles: (a) to maintain professional autonomy by fighting the idea of state medicine which appealed to much of the public, and (b) to ensure adequate recompense while still maintaining their service ideal of treating "all in need." The compromise that developed by the mid 1930s was the socialization of nursing and hospital care but not medical care. There was a definite switch in the tone of articles in The Canadian Medical Association Journal by 1934 from fighting against, to supporting and lobbying for, hospital

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[320] Agnew, H. (1937). The educational preparation of hospital administrators. The Canadian Medical Association Journal, 37, p. 500.

[321] By the end of 1933, a regular column appeared in the CMA journal which identified, analyzed, and suggested ways to deal with economic difficulties. A committee of the CMA was struck to study the economic situation (Cox, A. (1935). The report of the committee on economics. The Canadian Medical Association Journal, 32, pp. 436-438). One article suggested decreasing the number of students being admitted into medicine (McPhedran, H. (1935). The difficulties of the profession. The Canadian Medical Association Journal, 32, pp. 82-83). The first Alberta Medical Bulletin was published in April, 1935. "We are making this venture, hoping that by presenting information about movements affecting the profession or problems confronting them, in a more preservable form, it may become a forum of great value and interest to all" (Learmonth, G. E. (1935). Alberta. The Canadian Medical Association Journal, 32, p. 712). The bulletin primarily focused on legislation that could affect medical practitioners. Considering the frequency with which workman's compensation was discussed, it must have been one of the more stable sources of income for many physicians during the 1930s.

insurance programs including those that would be financed by provincial and federal government. [322] By this time, however, neither the Alberta nor Canadian governments could afford to pay for a comprehensive program. The government of Alberta did extensive studies from 1935 to 1938 and then tabled the plan for further consideration when economic conditions improved. [323]

Throughout the 1930s the nursing profession had no members elected to the legislature while the medical profession was well represented. [324] The health policy developments of the 1930s seemed to be more influenced by medical concerns than those of the nursing profession. The focus of the AARN during this period was in response to discussions flowing from the Weir Report.

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[322] Editor. (1930). Health insurance. The Canadian Medical Association Journal, 22, pp. 555-556; Rowan, A. A. (1930). A comprehensive state sickness insurance act. The Canadian Medical Association Journal, 22, pp. 831-834; MacDermot, J. H. Health insurance in British Columbia. The Canadian Medical Association Journal, 23, p. 173; Learmonth, G. E. (1934). Health insurance. The Canadian Medical Association Journal, 30, p. 79; Learmonth, G. E. (1934). The medical relief problem in Alberta. The Canadian Medical Association Journal, 30, pp. 201-203.

[323] Learmonth, G. E. (1935). A health insurance scheme for Alberta. The Canadian Medical Association Journal, 32, p. 439; Learmonth, G. E. (1935). Alberta. The Canadian Medical Association Journal, 32, p. 592.

[324] During the UFA administration, Drs. W. A. Atkinson of Edmonton and H. A. McGill of Calgary were MLAs (Editor. (1930). Alberta. The Canadian Medical Association Journal, 24, p. 604). With the Social Credit victory of 1935, Dr. W. W. Cross was appointed Minister of Health of Alberta. In subsequent by-elections in 1937, Drs. Walter Morrish of Edmonton and Peter. M. Campbell of Lethbridge gained seats in the legislature. During both the UFA and Social Credit administrations, Dr. Bow was Deputy Minister of Health (Learmonth, G. E. (1935). Alberta. The Canadian Medical Association Journal, 33, p. 459; Learmonth, G. E. (1938). Alberta. The Canadian Medical Association Journal, 38, pp. 95, 196).

Significant progress in political activity was evident in the briefs submitted by the AARN in consideration of the socialization of nursing and hospital insurance, and the lobbying around issues of nursing working conditions and educational standards.

## Status of Women

There was little public attention to the status of women in the 1930s, perhaps as many may had concluded the "problem" was solved with the success of the "Person's Case"; and the difficulties flowing from the Great Depression dominated the attention of the public. Throughout the Weir Report references were made to the low status of the nurse in the community and in the health sector. A description of one private duty nurse's work made her sound more like a domestic servant than a trained professional:

> We find the man of the house with pneumonia, his wife not in good health, the nurse on twenty-four hour duty, washing, ironing, baking bread, carrying wood and coal for fires, helping with the housework in general as well as having almost the entire responsibility of the patient, the doctor being able to pay a visit only every three or four days because of the distance. For this case the nurse received fifty cents a day, fifteen dollars a month. [325]

An editor commenting on the Weir report expressed his alarm that the recompense for nursing was so low. He continued, stating that it would be impossible to attract intelligent women

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[325] McCallum, K. B. (1935). Private duty, Manitoba style. The Canadian Nurse, 31, p. 73.

and men to nursing with these wages.[326] Dr. H. Agnew reported: "Nurses and others work far longer hours than has been permitted for years in most organized vocations."[327] However little improvement was made during the decade. In 1935 legislation was passed restricting a work week to between 44 and 48 hours with an eight hour day. These federal acts did not specify health institutions or health workers.[328] In 1936, the Alberta government passed The Hours of Work Act which applied to, "any industry, trade, or occupation" except for farming and domestic servants in private houses. The provision covering females stated that the hours, "shall not exceed eight in the day and forty-eight in the week."[329] The Female Minimum Wage Act of 1925 was amended in 1936. Surprisingly even with these federal and provincial acts limiting the work day and week, nurses throughout the 1930s still had not universally attained an eight hour day. The Alberta Federation of Labor passed a resolution in 1936 which stated, "Resolved, that this convention again reaffirm

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326 Editor. (1932). Nursing education in Canada. The Canadian Medical Association Journal, 26, p. 467.

327 Agnew, H. (1935). The hospital situation in Canada during 1934. The Canadian Medical Association Journal, 32, pp. 186-187.

328 Dominion of Canada. (1935). Statutes of Canada. Ottawa: Author, pp. 213-215, 381-385.

329 Government of Alberta. (1942). Revised statutes of Alberta. Edmonton: Alberta. pp. 3677-3684.

its demand for an eight-hour day for all nursing institutions within the province." [330]

A 1936 article discussed illness of student nurses that was attributed by their superintendent of nurses to the long working hours: 58 hours on duty per week for day nurses and 75 hours for night nurses. [331] The high incidence of tuberculosis among nurses became a concern in the 1930s. Although medical researchers examined the infectious process, none suggested a possible link between susceptibility and exhaustion due to long working hours. [332]

In 1939 Grace Fairley, the CNA president, advised nurses that an interprovincial superannuation was, "too far away for this generation to put any hope on, and it must come down to an individual basis and I do beg of you to look after yourselves." [333]

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[330] Editor. (1936). Resolutions passed by Alberta Federation of Labor. Alberta Medical Bulletin, 1(5), pp. 26-27.

[331] Editor. (1936). Can student nurses take it? The Canadian Hospital, 13(6), p. 16. In 1938 a CNA committee was still attempting to arrange eight hour duty, a limit of 96 working hours in a fortnight, one day off in one week or two in a fortnight (AARN. (October 6-7 1938). Minutes. Edmonton, p. 447).

[332] Editorial. (1932). Tuberculosis among nurses. The Canadian Medical Association Journal, 26, p. 465; Editorial. (1936). The protection of nurses against tuberculosis. The Canadian Medical Association Journal, 34, p. 682-683; Collins, R. J., & MacMillan, C. W. (1936). Tuberculosis and the student nurse. The Canadian Medical Association Journal, 34, p. 649-654). Wherrett, G. J. (1941). The tuberculosis problem in Canada. The Canadian Medical Association Journal, 43, pp. 295-299. The incidence of tuberculosis in nurses and student nurses was ten times the average for the rest of the population and exceeded "all other groups , the next being that of hard-rock mining...approximately six times the average" (p. 298).

## Development of the Nursing Profession

The AARN council matured noticeably during the 1930s: (a) it became more responsible to the membership by seeking opinions about important issues, [334] (b) it ensured good governance by insisting that councillors attend all meetings or resign, [335] (c) it encouraged more understanding and unity between the nursing education, public health, and private duty sections of the AARN by including as a non-voting member a representative of each section at its meetings, [336] (d) it improved communication between members and their official body by developing the idea of districts, [337] (e) it proposed a media watch

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[333] AARN. (April 11-12, 1939). Minutes. Edmonton, p. 475). Grant, M. D. (1930). When working days are over. The Canadian Nurse, 26, p. 236.

[334] Members were notified by letter of suggested changes to the constitution and bylaws and then they were discussed at an annual conference before being finalized (AARN. (February 6, 1939). Minutes. Edmonton, p. 470).

[335] AARN. (October 10-12, 1933). Minutes. Calgary, p. 344.

[336] AARN. (September 8, 1934). Minutes. Calgary, p. 355. The motion was made by Eleanor McPhedran and seconded by Sister Tougas.

[337] The idea originated from the Calgary Association of Graduate Nurses (AARN. (December 9, 1933). Minutes. Edmonton, p. 347). The relationship committee recommended local Graduate Nurses' Associations become part of provincial districts to ensure common policies throughout Alberta. The recommendation was sent with ballots to all members (AARN. (January 25, 1936). Minutes. Calgary, p. 390). Seven districts were formed (AARN. (June 22 1936). Minutes. Calgary, p. 406). The president and secretary considered visiting rural districts to help them set up their branches (AARN. (May 29, 1937). Minutes. Edmonton, p. 420).

That there was not immediate improvement with the restructuring was evident in Fanny Munroe's presidential address: "Elections...were a disappointment.... Criticism of the method of elections still comes in. Might I suggest that those who do the criticizing get together work out a better

to ensure that "pictures which are distasteful to the nursing profession may be banned," [338] and (f) it began to see the need to let the public know more about the value of nursing as a profession and the work of nurses. [339]

Autonomy

The AARN focused on two major initiatives to better conditions for nursing practice in the late 1930s: (a) it made amendments to its own constitution and bylaws; [340] and (b) it sent a recommendation to the AHA to include in its incorporation Act a requirement for the registration of all nurses employed in Alberta hospitals. [341] In 1939 the Hospital Act included a

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plan and send it to the council. No method however good can offset the apathy of those who don't vote" (AARN. (June 22 1936). Minutes. Calgary, p. 402). After four years as president she resigned September 17, 1936.

[338] AARN. (October 10, 1934). Minutes. Edmonton, p. 360.

[339] Wells, A. E. (1932). The need for publicity in health education. Canadian Public Health Journal, 23, pp. 344-347; Wells, A. E. (1932). Principles and methods of publicity in health education. Canadian Public Health Journal, 23, pp. 442-447. These articles could be forerunners of the newest endeavour in public health, social marketing. This continued throughout the thirties to be a main focus of public health (Bates, G. (1936). Public health education and national health. Canadian Public Health Journal, 27, pp. 13-19). McCormick, V. (1930). The nurse and the public (Part 1-VI). The American Journal of Nursing, 30, pp. 3-7, 182-186, 266-272, 439-443, 585-590, 739-743.

[340] AARN. (October 6-7, 1938). Minutes. Calgary, pp. 452-454.

[341] AARN. (May 29, 1937). Minutes. Edmonton, p. 423. The AARN suggested two discussion items for the conjoint meeting with the AHA in November, 1937: (a) the necessity of a adequate living wage commensurate "with the professional standing and service given" by hospital employed nurses, and (b) the importance of hospitals employing only registered nurses (AARN. (October 16, 1937). Minutes. Edmonton, p. 427).

requirement that nurses had to be registered. The Hospitals Act included a requirement that nurses had to be registered. [342] This was an important step towards ensuring the autonomy of the nursing profession.

Skill and Knowledge

In 1931, the UofA senate recommended standards for Alberta training schools that were similar to those in the Weir report. Although the minimum of one instructor was suggested, they did allow the assistant day superintendent to act in that position. No admission requirements were specified. [343] As early as the November 13-14, 1930 annual meeting the AARN had discussed the need for minimum entrance requirements, however it was explained that even though the act stipulated Grade VIII, no school was using this requirement, "Some of them take Grade IX, most of them Grade X and a lot of them require Grade XI." In 1932 Jean Brown, a member of the survey committee, discussed mental testing of students emphasizing that nurses could help to put in force higher admission standards. [344] On March 21, 1934 the long awaited amendments to the Registered Nurses Act were approved by the legislature. [345] Finally in 1937 the AARN sent a

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[342] AARN. (September 8, 1939). Minutes. Calgary, p. 494.

[343] AARN. (April 24, 1931). Minutes. Edmonton, p. 272.

[344] AARN. (March 22-23, 1932). Minutes. Edmonton, p. 297.

[345] The amendments included: (a) a change in minimum admission requirements from Grade VIII to Grade XI and (b) a new election procedure (Government of Alberta. (1934). Statutes of Alberta. Edmonton: Author, pp.

letter to Mr. Ottewell to be drawn to the attention of the Department of Education. It explicitly laid out minimum entrance requirements:

> The legal minimum for admission to a course of training leading to the standing of Registered Nurse is Grade XI of Alberta or its equivalent. Under the new course of studies this is interpreted to mean Grade XI as in the course for Normal School Entrance with Chemistry required. It should be pointed out that although Grade XI is the legal minimum, all but three of the Schools of Nursing in Alberta require complete Grade XII, with Chemistry II required and Biology I recommended. Students who hope to obtain a degree of Bachelor of Science in Nursing at a later date, should be advised that Senior Matriculation, including Chemistry II and Physics II is the requirement, with Biology I recommended. [346]

The wording would seem to indicate that this was not a suggestion to be negotiated but rather a notification by a profession which meant to set its own standards. The minimum requirements had to be temporarily lowered to Grade XI as a few schools were unable to secure students with Grade XII and Chemistry II, however, the standard remained for the Act. [347]

In 1939 suggested changes to the Registered Nurses Act included: (a) compulsory registration; (b) time limit for registration of new graduates, nurses from other provinces, and

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181-184). Thanks were sent to George Hoadley, Irene Parlby, Dr. Atkinson, and Mrs. J. W. Field for their help in having the Bill presented and passed (AARN. (October 10, 1934). Minutes. Edmonton, p. 357).

[346] AARN. (October 16, 1937). Minutes. Edmonton, p. 426.

[347] AARN. (February 6, 1939). Minutes. Edmonton, p. 470.

non registered nurses who are nursing; (c) Grade XII minimum admission requirement; and (d) prohibition and penalties. There was substantial progress made by the AARN in defining and ensuring the skill and knowledge component of the profession in the 1930s.

Service Ideal and Code of Ethics

A list of qualities of nursing leaders created by over one hundred student nurses in various training schools provided some understanding of women entering nursing at the time of the study. [348] The strong influence of Christian values was readily evident in the qualities. [349] There was no discussion concerning a code of ethics found in the AARN literature. Unlike the late

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[348] Some characteristics were: "(a) Genius for organization...; (b)... understanding of the foibles and weaknesses of mankind in general, and of patients, hospital administrators, and physicians in particular; (c) undaunted faith in the fundamental worth of their programme and prophetic vision in laying foundations of enduring worth; (d) lofty idealism combined with a sane perspective of the practical; (e) action that brings results, rather than cloudy theorizing; (f) the zeal of the missionary and ambition of the pathfinder; (g) piety without prudery; (h) finesse without opportunism; (i) unflagging devotion to duty without prime thought of mercenary award; (j) courage to champion a worthy cause...; (k) sound moral outlook...; (l) inspiration by living example as well as by precept; (m) tenderness and love for humanity...; (n) sympathy without...sentimentality; (o) severity...without vindictiveness; (p) ability to discipline subordinates without...haughty heartlessness...; (q) supreme capacity for administration without losing sight of the larger issues; (r) gracious and engaging personality...; (s) high intelligence; (t) sound academic, professional, and technical training; (u) healthy physique; (v) human beings rather than magicians" (Weir, G. M. (1932). Survey of nursing education in Canada. Toronto: UofT, pp. 38-39).

[349] Even at the end of the decade the AARN and CNA expressed concerns about developing religious influence in the life of the nurse. A national religious guild was formed (AARN. (March 22, 1937). Minutes. Edmonton, p. 420; AARN. (April 11-12, 1939). Minutes. Edmonton, p. 475).

1920s when the ANA was drafting a code [350] there was seldom any mention of ethics in any of the nursing journals reviewed.

During the 1930s the AARN had become more proactive regarding its own organization and health policy. It had input into discussions regarding socialization of nursing and the insuring of hospital care which appeared to have impact on government thinking. The AARN was also active in seeking improvements to educational standards in nursing, many of which were achieved. These improvements would have had an impact on health care services in Alberta. Of lesser success were the activities of the AARN to improve working and living conditions for its membership. Studies in this period clearly indicated the poor conditions were negatively affecting health care services. Unlike some nursing organizations [351] the AARN was seldom

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[350] The draft developed in 1926 had no been formally adopted by the end of the 1930s (Limbert, P. M. (1933). Developing a code of ethics for the nursing profession. The American Journal of Nursing, 33, pp. 1257-1263).

[351] In 1930 Adelaide Nutting wrote to the ICN, "I have long wished that we nurses might feel a larger responsibility for doing our share in some of these great world movements. As women dedicated to saving human life and safeguarding human health, surely we should be looked to for intelligent co-operation, as far as lies in our power, in all efforts for the advancement of peace" (Editor. (1930). Disarmament and peace. The International Nursing Review, 5(5), p. 29). Other article were printed on this social responsibility (Editor. (1932). Disarmament and the nursing profession. The International Nursing Review, 7, pp. 98-102; Lloyd, A. C. (1931). Social responsibility: An aim in nursing education. The American Journal of Nursing, 31, pp. 907-911; Wald, L. D. (1931). Editorial. The American Journal of Nursing, 31, pp. 1392-1394; Catt, C. C. (1931). Disarmament. The American Journal of Nursing, 31, p. 1394; "Gelinas, A. (1935). The nurses and her relation to community needs. The American Journal of Nursing, 35, pp. 22-24).

involved in social or political issues which did not have a direct impact on the profession. As the AARN entered the 1940s it was still faced with the significant challenge of improving the status of nurses.

# Chapter V

## AARN in the 1940s: Changing Direction

The 1940s brought a new set of challenges to the AARN. Its credibility as a profession was established, however its role within the sector of health professionals was unclear. Throughout the war years the AARN struggled to meet the nursing shortage in Alberta arising from the need for more and more nurses to do war work. The professional association was undergoing internal problems, particularly with the Catholic nursing orders over the entrance requirements. Autonomy was threatened when the government of Alberta and the UofA became more involved in directing the work of the AARN. The association had outgrown its volunteer model and had to begin to develop a corporate model to carry on every day business. Throughout the post-war period the AHA sought its cooperation and collaboration, but on issues of funding and health care services not health policy. In this partnership the AARN was being molded into an organization with an increasing labour relations focus.

During the first three years of the 1940s a number of major studies were completed by the Dominion government which revolutionized health and social policy: (a) in 1940, The Rowell-Sirois Royal Commission reported on the Dominion-Provincial relations; [352] (b) in 1943, The Heagerty Report [353] focused on

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352 The report was viewed as a "masterpiece" in investigation and a "landmark" in Canadian social history. The commission stated it was impossible to establish a wage for Canadians which would allow for unpredictable events like serious illness, prolonged unemployment,

health insurance in Canada; and (c) in 1943, The Social Security Report [Marsh report] examined the need for social and economic security. [354] "By the 1940s...social security had become not only an avowed, national aim, but an international idea." [355] L. Marsh wrote that the 1930s taught some basic lessons: (a) "Provision for unemployment both economically and socially, is the first and greatest need in a security programme designed for the modern

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accident, and premature death. The plan proposed the federal government "rent" taxing powers from the provinces, assume the provinces' debts, and then pay them adjustment grants so there would be one national level for services. Alberta, Quebec, and Ontario refused to cooperate fully with the investigation and refused to consider the report because they would receive no adjustment grants under the scheme. The provinces were to be primarily responsible for providing medical and hospital services because of their very different social and economic conditions and social views (Editor. (1940). Health insurance and public health studied by Royal Commission. Canadian Hospital, 17(8), pp. 14-15; McInnis, E. (1982). Canada: A political and social history. Toronto: Holt, Rinehart & Winston, p. 543; Marsh, L. C. (1975). Report on social security for Canada. Ottawa: Government of Canada, pp. xv, 10).

[353] Dr. J. J. Heagerty, director of public health service in the Department of Pensions and National Health, chaired this advisory committee that studied health insurance (Marsh, L. C. (1975). Report on social security for Canada. Ottawa: Government of Canada, p. xxii). The general secretary of the CMA declared that he had been guaranteed that the CMA would "be consulted, not after health insurance legislation has been drafted, but before such legislation sees the light of day" (Routley, T. C. (1941). Letter to the editor. The Canadian Medical Association Journal, 46, p. 391).

[354] The Marsh report was regarded by some as a "blueprint for postwar social policy" (Kealey, G. (1990). Writing about labour. In J. Schultz (Ed.), Writing about Canada (pp. 145-174). Scarborough, Ont: Prentice-Hall, p. 153). L. Marsh believed that the two major components of social security were health insurance and unemployment insurance (Marsh, L. C. (1975). Report on social security for Canada. Ottawa: Government of Canada, pp. 20-30, 118-125, 185-194).

[355] Marsh, L. C. (1975). Report on social security for Canada. Ottawa: Government of Canada, p. xvii).

industrial economy"; and (b) "In the absence of organized provision for particular categories...of need...unemployment relief...draws into itself all other kinds of need: sickness, disability, widowhood, desertion, loss of residence requirements and so forth." [356] The Marsh report was meant to plan a system that would prevent the economic and social devastation of the 1930s from ever occurring again and to plan for the post-war world when thousands of people from the armed forces would need to be demobilized and re-employed. [357] L. Marsh declared, "The general sense of security which would result from the continuity of income provided by these various types of protection would provide a better life for the great mass of people." [358]

The nurses in Alberta, like in the rest of Canada, were just starting to recover from the social and economic devastation of

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[356] *Ibid.*, 7-8. L. Marsh wrote that there were three basic reasons for social insurance programs: (a) the unpredictability of what hazards and when they might occur, (b) the financial inability of the majority of people to meet unexpected problems, and (c) the financial security of the community pooling resources to provide for these contingencies (p. 10).

[357] *Ibid.*, 15. L. Marsh cautioned about the problem of inequality that would be apparent to civilians when the armed forces and their families were provided with "social security" programs unless social programming was universal.

[358] *Ibid.*, 17. The Marsh report led to The Family Allowance Act of 1944 (Dominion of Canada. (1952). Revised statutes of Canada. Ottawa: Author, pp. 2803-2808); The Old Age Assistance Act of 1951 (Dominion of Canada. (1952). Revised statutes of Canada. Ottawa: Author, pp. 4117-4123); and The Old Age Security Act of 1951 (Dominion of Canada. (1952). Revised statutes of Canada. Ottawa: Author, pp. 4125-4129).

the 1930s when WWII began. The work involved in helping to support the membership of the AARN during these trying times became more than a "volunteer" staff could handle. On February 10, 1940 A. E. Vango, AARN registrar/secretary/treasurer, submitted her resignation because of the burden of the workload. In March of 1940 the AARN appointed a committee [359] that recommended that A. E. Vango: (a) continue for another year working about one hour per day on full salary; (b) set up a permanent office at St. Joseph's College, UofA; and (c) hire a full-time stenographer at $85.00 per month. [360] In 1941 it was proposed that a nurse be hired to act as registrar and advisor to schools of nursing. [361]

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[359] The committee consisted of Agnes Macleod, A. E. Vango, and Ida Johnson (AARN. (February 10, 1940). Minutes. Edmonton, p. 499).

[360] According to the AARN minutes, the January 11, 1941 meeting was held at St. Stephen's College. The reference to St. Joseph's was probably an error. "In 1932 there was progress in the appointment of A. E. Vango, R.N., to the permanent paid position of registrar-secretary-treasurer. A. E. Vango's salary was seventy-five dollars a month and she opened the office in St. Stephen's College on the University campus" (Cashman, T. (1966). Heritage of service. Edmonton: AARN, p. 210). According to the minutes, until May, 1940 the AARN office had been operating out of A. E. Vango's home (AARN. (March 25, 1940). Minutes. Calgary, p. 512).

[361] AARN. (March 25, 1940). Minutes. Calgary, p. 513. In 1942, A. E. Vango once again submitted her resignation (AARN. (November 21, 1942). Minutes. Calgary, p. 543). Finally, on April 26, 1943 Ruth Gavin was appointed secretary/treasurer (AARN. (April 26, 1943). Minutes. Calgary, p. 548). Ruth Gavin resigned after six years in the position and was replaced by Ruth Corbett (AARN. (August 30, 1946). Minutes. Edmonton, pp. 603, 598). On July 23, 1943 Elizabeth Pearston was hired as registrar/ school advisor (AARN. (July 23, 1943). Minutes. Edmonton, p. 549). Elizabeth Pearston resigned to return to hospital nursing in February, 1945 and Ella Howard was appointed as acting registrar on February 1, 1945 (AARN. (January 20, 1945). Minutes. Edmonton, p. 568). E. Bell Rogers was ratified as registrar at the March 24, 1945 AARN meeting.

As the host for the CNA 1940 biennial meeting in Calgary the AARN sent a number of articles to The Canadian Nurse to introduce delegates to the province. [362] The journal was still struggling financially in 1940 when Agnes Macleod suggested that annual fees be increased to four dollars and a subscription be provided to each registered nurse. [363] This idea was not implemented. Instead Violet Chapman was appointed to increase subscriptions and by 1944 she reported an increase from 6% to 29% of the membership. [364]

The CNA [365] took a strong leadership role in nursing during the war. Its experience in WWI stimulated it to begin early development of plans to meet the expected shortage of nurses. In 1942, in response to a brief from the CNA, the Canadian government provided grants for nursing education to help

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[362] Brighty, K. S. (1940). Dunvegan Crossing. The Canadian Nurse, 36, pp. 136; Emerson, B. A. (1940). In Northern Alberta. The Canadian Nurse, 36, pp. 137-140; Chittick, R. (1940). Nursing comes to the last frontier. The Canadian Nurse, 36, pp. 201-205; Johns, E. (1940). A true western welcome. The Canadian Nurse, 36, pp. 487-490.

[363] AARN. (March 25, 1940). Minutes. Calgary, p. 513. A. Macleod wrote to E. Johns asking for a reduction in subscription price, to implement the plan, but received a negative reply by the October 26, 1940 meeting. At the January 11, 1941 meeting the AARN reported the fourth highest subscription rate in Canada (Minutes. Edmonton, p. 521).

[364] Alberta had the highest subscription rate in Canada. Students with honors in their registration examinations were given a year's subscription (AARN. (August 12, 1944). Minutes. Edmonton, p. 563).

[365] In 1940, there were 16,758 members represented by the CNA (CNA. (1968). The leaf and the lamp. Ottawa: Author, p. 88).

alleviate the shortage of nurses. [366] The government demonstrated its confidence in the nursing profession when it left the administration of these grants to the CNA. [367] The recommendation made by the AARN to the CNA to appoint Kathleen Ellis as the Emergency Nursing Advisor to coordinate the CNA's and the provincial associations' work related to the shortage of nurses was accepted. [368] Ellis was to help implement recommendations made by a CNA advisory committee: (a) to establish post-graduate courses to meet new demands upon the nursing profession; (b) to improve working, living, and educational conditions for student nurses; (c) to improve clinical education through visiting instructors; (d) to develop courses for married and retired nurses returning to the work force; (e) to improve the status and wages of general duty nurses; and (f) to

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366 Grace Fairley, CNA president and ICN third vice-president, stated that Senator Cairine Wilson helped the delegation that met with government leaders (Fairley, G. M. (1942). Faith and courage. The Canadian Nurse, 38, pp. 15-16). The initial grant was $115,000.00. The grants could be used for education programs, recruitment, administration, and bursaries (Lindeburgh, M. (1942). Response from the federal government. The Canadian Nurse, 38, pp. 543-544).

367 Editor. (1943). Something to show for it. The Canadian Nurse, 39, pp. 99-100.

368 The AARN recommended K. Ellis of the SRNA because of her broad nursing experience and her knowledge of Canada (AARN. (October 25, 1941). Minutes. Edmonton, p. 530). The work entailed ensuring the standards of nursing education and registration did not deteriorate but improved (Editor. (1942). Miss Kathleen W. Ellis appointed emergency nursing advisor to C.N.A. Canadian Hospital, 19(3), p. 39; Ellis, K. W. (1942). To meet the shortage of nurses. Canadian Hospital, 19(12), p. 19).

establish central schools of nursing. [369] There seemed to be three subjects in the CNA strategy to meet the nursing needs of Canadians at home and overseas: (a) student nurses, (b) graduate nurses, and (c) subsidiary workers. To a much lesser degree the CNA and provincial associations encouraged the public to assume more responsibility for its health and thereby decrease the demands on nursing care at home. People were encouraged to take first aid courses, many of which were taught by nurses. Public health nurses assumed most of the responsibility for encouraging active participation of the public in their own health care.

The CNA recognized the importance of publicity campaigns at national and provincial levels in 1940 when it developed a pamphlet for student recruitment that could be utilized by the provinces. [370] The AARN utilized this pamphlet in publicity packages it distributed to all high schools, schools of nursing and the Department of Health. Provincial entrance requirements and nursing opportunities available were also included in the

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[369] Ellis, K. S. (1942). New ways in wartime. The Canadian Nurse, 38, pp. 160-164). M. Fraser convened the AARN committee working with K. Ellis (Ellis, K. S. (1942). The provinces go into action. The Canadian Nurse, 38, p. 239.

[370] AARN. (October 26, 1940). Minutes. Edmonton, p. 518; Lindeburgh, M. (1942). Our national duty. The Canadian Nurse, 38, pp. 759-763; Ellis, K. W. (1942). The publicity campaign. The Canadian Nurse, 38, pp. 791-793; Ellis, K. W. (1942). Reaction to publicity. The Canadian Nurse, 39, pp. 105-108.

package. [371] In 1942, the AARN struck a recruitment and publicity committee and made an all out effort to attract high school students into the profession through radio announcements, pamphlet distribution, and speaking tours by Jean Clark to 7700 high school students in a two year period. [372] Realizing that students may be prevented from entering nursing due to the entrance fees, the AARN provided financial aid through dominion-provincial grants. [373] Some students lacked the entrance requirement Chemistry II because their schools did not have laboratory facilities, therefore a summer course was set up and free tuition, transportation, room and board were provided. [374]

The professional associations were well aware that working and living conditions of many student nurses were a deterrent to recruitment of high school graduates who now had a choice of

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[371] AARN. (October 25, 1941). Minutes. Edmonton, p. 528.

[372] AARN. (February 7, 1942). Minutes. Edmonton, p. 533. Helen Peters as convenor obtained a grant for $9,400.00 to help increase enrollment (AARN. (September 26, 1942). Minutes. Provincial office, Edmonton, p. 540; AARN. (March 30, 1944). Minutes. Edmonton, p. 556). Jean Clark was released from her public health position until September, 1944 to assist in recruitment (AARN. (March 31, 1944). Minutes. Edmonton, p. 560; July 14, 1945). Minutes. Edmonton, p. 583).

[373] Students receiving grants were to go to a designated school, but as this was not a successful policy it was rescinded in 1944 (AARN. (October 11, 1943). Minutes. Edmonton, p. 551; AARN. (January 26, 1944). Minutes. Edmonton, p. 554; AARN. (August 12, 1944). Minutes. Edmonton, p. 563).

[374] AARN. (October 11, 1943). Minutes. Edmonton, p. 552; AARN. (March 31, 1944). Minutes. Edmonton, p. 558.

many occupations. [375] In 1941 the AARN reported that some student nurses were still being exploited when they were sent to "special" patients and the fees collected were kept by the hospital. [376] Formal inspections of schools of nursing and advisors to schools of nursing were encouraged and supported by the AARN to ensure the best possible living and working conditions and high educational standards; however throughout the war the inspections were cancelled due to lack of money or time. [377] K. Ellis stated the advisor was to help ensure minimum standards with regard to curriculum, supervision, entrance requirements and to approve schools of nursing. [378] In 1944 some of the grant money was made available to help schools of nursing with higher than normal enrollment. [379]

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[375] Margaret McLean reported six of ten schools now provided student lectures during duty hours (AARN. (April 14-15, 1941). Minutes. Lethbridge, p. 524). In 1944 it was suggested that student nurses be allowed 'a week each year sick time (non-accumulative) (AARN. (January 26, 1944). Minutes. Edmonton, p. 555). The UofA school of nursing agreed to trial the sick time allowance (AARN. (January 20, 1945). Minutes. Edmonton, p. 566). The CNA and AARN requested reduced train rates for nursing students but were denied by the Canadian Passenger Association with no explanation given in the minutes. Other students were entitled to this discount (AARN. (October 26, 1945). Minutes. Edmonton, p. 586).

[376] AARN. (January 11, 1941). Minutes. Edmonton, p. 521.

[377] The money for the 1940 inspection was used to establish the provincial office (AARN. (March 25, 1940). Minutes. Calgary, p. 513). The 1941 inspection was cancelled because of the nurses' increased work load due to the war (AARN. (May 17, 1941). Minutes. Edmonton, p. 527).

[378] Ellis, K. (1938). The scope and functions of the advisor to schools for nurses. Canadian Hospital, 15(2), p. 15.

[379] Grants were for clerical help, health services, teaching facilities, classroom and laboratory equipment (AARN. (October 11, 1943).

In 1941 minimum entrance requirements for schools of nursing were equivalent to university entrance. [380] A great deal of internal and external pressure was placed on the AARN during the war to reduce these high standards. [381] In February and May 1942 the Catholic administrators of hospitals requested that the entrance requirements be decreased. The AARN refused until it could be proven that the entrance requirements were creating the shortage of students and not other factors such as increased opportunities in other areas of work for women and the cost of entrance fees for nursing education at some hospitals. [382] At the

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Minutes. Edmonton, p. 551). In 1945 grants totalling $3,000.00 were made to eleven schools of nursing (AARN. (January 20, 1945). Minutes. Edmonton, p. 565).

[380] An amendment to the registration act in 1941 increased the entrance requirement to Grade 12 with Chemistry II and either Physics II or Biology (AARN. (January 11, 1941). Minutes. Edmonton, p. 521; Government of Alberta. (1942). Revised statutes of Alberta. Edmonton: Author, pp. 3905-3907).

[381] Elizabeth Pearston attended a meeting with a number of other organizations to discuss the shortage of nurses at Drumheller Municipal Hospital. After much discussion it was decided, "that salaries, special duty nurses and shortages of nurses be left with the provincial association" (AARN. (January 26, 1944). Minutes. Edmonton, p. 553).

[382] Sister Neuhausel, superintendent of nurses at the Edmonton General, sent a letter to the UofA requesting the entrance requirements be reduced in order to recruit more students and "an individual member of the Lethbridge District had approached Dr. Campbell, M.L.A., in connection with a proposed amendment to the Act." Probably this was Sister Beatrice. Both were censured for not going through proper channels within the professional organization. A five to one vote of the council decided to give the Act a "fair trial." Helen Peters reported that on a survey of all nursing schools, when there was more than one hospital in a community, "Catholic hospitals blame the educational standards for their difficulties and the other hospitals state they are not experiencing such difficulties, or if they are, they attribute them to other causes" (AARN. (February 7, 1942). Minutes. Edmonton, pp. 531-532).

annual meeting in April 1942, the Catholic Sisters brought up the question of lowering the entrance requirements a number of times and each time they lost the argument. [383] In April 1943 Sister Mansfield of the Holy Cross Hospital and Sister Neuhausal of the Edmonton General Hospital reported having accepted students with less than minimum entrance requirements. [384] Once again the AARN general meeting carried a motion insisting that the minimum requirements of the 1941 Act be given a "fair trial" until 1944 when the results of recruiting and dominion-provincial grants had been studied. [385] On March 31, 1944 the legislation committee recommended that no changes be made in the Act because: (a) there was no official standing between the Grade XI and Grade XII diplomas that could be designated, (b) there were sufficient qualified students, and (c) there was a significant cost involved in changing legislation. The minutes report that the recommendation was received without discussion. [386]

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[383] AARN. (April 6-7, 1942). Minutes. Edmonton, p. 537. A report of this meeting was published in The Canadian Nurse in May, 1942 (38, pp. 313-314).

[384] AARN. (April 25-26, 1943). Minutes. Calgary, p. 545.

[385] AARN. (October 11, 1943). Minutes. Edmonton, p. 550.

[386] AARN. (March 31, 1944). Minutes. Edmonton, p. 559. There was no further discussion until after the war.

Both the CNA and the AARN worked toward improving the theoretical and practical components of the nurse's education to ensure graduating nurses would be able to meet new demands on the nursing profession. [387] From 1942 to September 1944 Jean Clark acted as travelling instructor to nursing schools. As there had been a significant improvement in the RN examination papers during that period, it was decided to continue the position even though the 1945-1946 federal grants had been decreased by more than one half. [388]

It was proposed that a centrally located school for exclusive instruction in theory, combined with a decentralized clinical practice component based in hospitals, might be an alternative to improve the quality of nursing education and to help increase the number of nursing graduates. In 1941 the AARN set up a committee to investigate this idea in more detail. [389] Notwithstanding the tension that again developed with the

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[387] Ellis, K. S. (1942). New ways in wartime. The Canadian Nurse, 38, pp. 160-164. A recommendation that a teaching and supervision course be included with the public health component of the Bachelor of Science in Nursing degree was endorsed by the AARN and a delegation met with Premier Manning to discuss it (AARN. (January 26, 1944). Minutes. Edmonton, p. 555; AARN. (March 26, 1945). Minutes. Calgary, p. 574).

[388] AARN. (March 26, 1945). Minutes. Calgary, p. 573; AARN. (May 12, 1945). Minutes. Edmonton, p. 580. K. Herman was appointed travelling instructor for 1946 (AARN. (October 26, 1945). Minutes. Edmonton, p. 585).

[389] AARN. (January 11, 1941). Minutes. Edmonton, p. 521.

Catholic Hospital Association [390] and the Catholic nursing schools, [391] the AARN continued to study the establishment of a central school of nursing. In 1942 a brief was sent to the UofA and to the Superintendents of nursing schools asking for their opinions concerning a central school. Although the idea was supported by the government and many hospital boards, the plan had to be tabled because there was no building suitable and no funds to build one. In 1944 a central school was again brought to the the UofA for its consideration. [392]

The CNA and AARN recognized the need for improving working and living conditions for graduate nurses to ensure their retention in nursing. Most nurses were still working longer days and more hours per week than the laws of Alberta allowed. [393] In

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[390] At its regional meeting in Winnipeg June 25-26, 1941 it rejected the proposed plan on religious grounds (AARN. (October 25, 1941). Minutes. Edmonton, p. 529).

[391] Sister Beatrice submitted two resolutions opposing a central school: one on behalf of the Lethbridge district and one for the Catholic schools of nursing (AARN. (February 7, 1942). Minutes. Edmonton, p. 532).

[392] AARN. (October 25, 1941). Minutes. Edmonton, p. 530. (AARN. (January 26, 1944). Minutes. Edmonton, p. 555). In 1948, a survey of excess students for nursing programs indicated there would be enough to have a central school plus the eleven hospital schools (AARN. (April 3, 1948). Minutes. Edmonton, p. 708). T. Cashman traced the idea of a central school from Margaret Fraser in 1941 through to 1950. The idea was then set aside. It was finally piloted in 1966 at Mount Royal Junior College in Calgary (Cashman, T. (1966). Heritage of service. Edmonton: AARN, pp. 237-238).

[393] Margaret McLean reported a trend toward better working hours, especially for night duty (AARN. (April 14-15, 1941). Minutes. Lethbridge, p. 524). Mrs. R. Eaton in 1940 at the CNA biennial meeting argued:

> Over and over again, while we were talking of acceptable hours of work some nurse would say, "That is right and what we need, but the

1942 the AARN made up a sliding scale of salaries for general duty nurses as guidelines for employers. [394] Continuing education courses were developed and subsidized by the AARN. [395] When the CNA recommended that all nurses be required to have St. John's Ambulance First Aid the AARN decided to promote these classes but not make them compulsory. [396] Married and retired graduate nurses were encouraged to return to the work force. To facilitate their reentry, refresher courses were developed and temporary

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> hospital cannot afford it". It did not seem to occur to many nurses that the needs of other workers are met by hospitals. Maids, janitors, orderlies, painters, electricians, plumbers, stenographers, and telephone operators working in the institution have reasonable hours of work. This whole problem of the cost of hospitalization will not be solved by economics effected through curtailing salaries and increasing the hours of work for nurses, and I regret that the average nurse assumes a personal responsibility which I do not think any one should expect her to carry.

A report was given by the Lethbridge district on its unsuccessful attempt to establish eight hour duty for private duty nurses because of the shortage of nurses (AARN. (March 31, 1944). Minutes. Edmonton, p. 558).

[394] AARN. (April 6-7, 1942). Minutes. Edmonton, p. 535. The legislation committee investigated the possible coverage of nurses with tuberculosis under the Workmen's Compensation Board (AARN. (August 12, 1944). Minutes. Edmonton, p. 564). Discussions as to the BC nurses' protection led to a brief in 1947 (AARN. (February 1, 1947). Minutes. Edmonton, p. 638).

[395] H. McArthur was director of these summer courses in public health, teaching, supervision, obstetrics, and administration until her appointment as Superintendent of the Public Health Nursing Branch in 1944 (AARN. (October 11, 1943). Minutes. Edmonton, p. 551; AARN. (January 26, 1944). Minutes. Edmonton, p. 555). M. McCulla, Assistant Director of Nursing of the UofA took over the position (AARN. (August 12, 1944). Minutes. Edmonton, p. 562).

[396] AARN. (March 25, 1940). Minutes. Calgary, p. 506. Possibly they felt it would be difficult for nurses in outlying districts to take the course.

certificates were granted. [397] Despite the demand for additional nursing staff the AARN did not lower its standards for registered nurses. It continued to monitor the hospitals to ensure that they were abiding by the Hospitals Act and hiring only registered nurses. In 1940 a survey was sent to eighty-eight hospitals in Alberta asking for a list of their nursing staff. Of the 732 nurses listed, ninety-nine were unregistered. Following a letter thirty-one of these paid their registrations. Spirit River, Cardston, Cereal, Fort Smith, Mundare, and Willingdon did not respond to the survey. [398] In 1941 a letter was sent to public health bodies, city health departments, and the AMA urging all to employ only registered nurses. [399] Initial registrations increased markedly when the UofA began to collect the $5.00 fee with the examination fee. [400] Provincial fees for overseas nurses were deferred until they returned to Canada. [401] In 1940 and 1941, to help improve communication among all Alberta nurses, the AARN

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[397] AARN. (February 7, 1942). Minutes. Edmonton, p. 531.

[398] AARN. (October 26, 1940). Minutes. Edmonton, p. 515. In 1940, the AHA invited AARN representatives to discuss the effects of the war on nursing. Topics discussed included: requisitioning married and older nurses, concern about maintaining the course length and entrance standards, using subsidiary workers, and setting up a centralized school (Editor. (1940). Effect of war upon nursing profession. Canadian Hospital, 17(11), pp. 44, 46).

[399] AARN. (October 25, 1941). Minutes. Edmonton, p. 528.

[400] *Ibid.*, p. 528.

[401] AARN. (May 17, 1941). Minutes. Edmonton, p. 527. Nurses with active membership in the AARN numbered 1,280.

divided the province into eight districts [402] and the nursing sections were renamed to reflect the increased trend to hospitalization of patients. [403] Perhaps due to concern with loss of their independence, many private duty nurses initially resisted working in hospitals, thereby compounding the shortage of nurses available to work in hospitals. Since the war, the conditions of private duty nurses had improved significantly; they were receiving more than enough work, better wages, and improved hours. However the hospitals were still lacking adequate staff. [404] In 1943, the National Selective Service report showed that the number of nurses in private duty was 29%, half of the number reported in the Weir report in 1932. Forty-eight per cent of nurses were working in hospitals and schools of nursing, 14.6% in public health and 8.4 % in other fields. [405] In the 1940s the general duty nurse suffered from low status, similar to the dilemma of the private duty nurses in the 1930s. In an attempt to

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[402] The eight districts in order of formation were Northern, Ponoka, Calgary, Medicine Hat, Drumheller, Red Deer, Edmonton, and Lethbridge (AARN. (March 25, 1940). Minutes. Calgary, pp. 503-513; AARN. (October 26, 1940). Minutes. Edmonton, p. 515).

[403] AARN. (April 14-15, 1941). Minutes. Lethbridge, p. 525. The new sections were called public health nursing section, hospital and school of nursing section, and general nursing.

[404] Nursing registries were asked to urge their members to take on general duty during the holidays the nurses would be paid at the senior nurse level (AARN. (April 25-26, 1943). Minutes. Calgary, p. 544).

[405] Ellis, K. W. (1943). The final report. The Canadian Nurse, 39, pp. 531-533.

raise the status of the general duty or staff nurse many articles were written in The Canadian Nurse.[406] In 1944, the AARN applied for a federal grant of $431.20 to set up a "placement bureaux" to help ensure adequate hospital staffing.[407]

By 1942 it was apparent that the war was not going to be quickly settled and that there was a need for long term planning to ensure support for the overseas forces and to maintain the health of Canadian citizens at home.[408] The CNA and AARN were being pressured by the Red Cross, St. John's Ambulance, and the government[409] to consider alternatives to meet the nursing

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[406] Baker, M. M. (1942). Wanted-leaders in the general nursing section. The Canadian Nurse, 38, pp. 405-407; Lawrie, A. F. (1942). A plea for the general duty nurse. The Canadian Nurse, 38, pp. 409-411; McIlraith, E. C. (1943). What we expect of general staff nurses. The Canadian Nurse, 39, pp. 533-534; Baird, I. (1943). A new deal for the general staff nurse. The Canadian Nurse, 39, pp. 589-590; Curley, R. (1943). Is general staff nursing worthwhile? The Canadian Nurse, 39, pp. 675-676.

[407] AARN. (August 12, 1944). Minutes. Edmonton, pp. 562-563. A pilot project was run in Edmonton in conjunction with the regional registry. Margaret Cogswell was hired as director (AARN. (July 14, 1945). Minutes. Edmonton, p. 581; Margaret Kerr, M. E. (1945). Interesting people. The Canadian Nurse, 41, p. 895).

[408] On December 7, 1941 the USA entered the war following the bombing of Pearl Harbor by the Japanese. Also in December 1941. the Canadians were part of the forces that attempted unsuccessfully to defend Hong Kong from Japan. On August 19, 1942, Canadians lost a battle at Dieppe (Marsh, J. H. (1985). The Canadian encyclopedia. Edmonton: Hurtig, pp. 1975-1977).

[409] Dr. McGugan, medical inspector of hospitals, warned the AARN to deal with the shortage of nurses before another group created a program using untrained or semi-trained workers that would be detrimental to both the nursing profession and to patient care (AARN. (April 6-7, 1942). Minutes. Edmonton, pp. 534-535).

shortage such as more schools of nursing, [410] accelerated courses, [411] or subsidiary workers. [412] The AARN set up a committee to study legislation in relation to subsidiary workers. [413] Dr. Bow, Deputy Minister of Health, recommended that the AARN obtain legislation before the Nurses' Aide group decided to apply for a separate Act. It was decided that the CNA would be approached for guidance with regard to legislation for subsidiary workers. [414] Although the hospitals indicated they could use one hundred trained ward aides, [415] the majority of nurses in the districts did not want this type of worker. [416]

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[410] Dr. McGugan suggested the need for three or four more schools. Rae Chittick stated that, "The opening of training schools requires staff and money, time and planning" (AARN. (April 6-7, 1942). Minutes. Edmonton, pp. 534-535).

[411] Fidler, N. (1944). The preparation for professional nursing. The Canadian Nurse, 40, pp. 621-626. A two year program was not implemented until after the war. The AARN recommended to the CNA that the experiment in two year education of a registered nurse be carried out (AARN. (August 30, 1946). Minutes. Edmonton, p. 612; Fidler, N. D. (1949). The Canadian Nurses' Association's demonstration school of nursing. The Canadian Medical Association Journal, 60, pp. 514-516; CNA. (1968). The leaf and the lamp. Ottawa: Author, p. 89).

[412] The CNA nursing education committee was studying these possible alternatives (AARN. (October 11, 1943). Minutes. Edmonton, pp. 551-552). A successful experiment in the use of practical nurses with a six month training program began in London, Ontario in September 1941 (Editor. (1942). Training practical nurses. The Canadian Nurse, 38, p. 407).

[413] AARN. (August 12, 1944). Minutes. Edmonton, p. 562. The committee considered ways to control nurses' aides, deciding to leave it with the hospitals.

[414] AARN. (January 26, 1944). Minutes. Edmonton, p. 554.

[415] Sixty-four of ninety-seven Alberta hospitals replied to a survey asking for their requirements related to trained ward aides. A total of 100

A survey of nursing service which included the compulsory registration of all graduate nurses (active, inactive, married, and single) [417] was conducted in March, 1943 by the CNA, [418] the Canadian Medical Procurement and Assignment Board, and the Selective Service Women's Division. Identifying an acute shortage of general duty nurses, the joint committee contended that if there was to be improvement in numbers while still attracting the best new students it would be necessary for working hours and wages to be similar to those of other occupations with the same educational preparation.

In November 1943 the CNA formed its first labor relations committee with Esther Beith as chairperson. Its mandate was to propose a national policy statement about the relationships between nurses and trade unions. [419] In August, 1944 the AARN

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,ward aides could be utilized, but administrators stated few local women were available (AARN. (October 11, 1943). Minutes. Edmonton, pp. 551-552).

[416] AARN. (August 12, 1944). Minutes. Edmonton, p. 564.

[417] AARN. (October 11, 1943). Minutes. Edmonton, pp. 550-551. K. Ellis reported that Mrs. R. Eaton, Director of National Selective Service (women's division) had mentioned the possibility of taking over local registries (AARN. (January 26, 1944). Minutes. Edmonton, p. 553).

[418] CNA president Fanny Munroe and first vice-president Rae Chittick, elected in 1944, had been AARN presidents. In 1944 other Albertans were involved in the CNA: (a) Helen McArthur, chairperson of the public health section; (b) Jean Clark, secretary of the public health section; and (c) Gena Bamforth, first vice-president of the hospital and school of nursing section.

[419] CNA. (1968). The leaf and the lamp. Ottawa: Author, pp. 88-89. The CNA public health section took the lead in recommending salary levels, vacation pay, sick leave, and pensions for staff and supervisors in public health (CNA. (1968). The leaf and the lamp. Ottawa: Author, p. 89).

set up a labor relations committee with Kathleen Connor as convenor. [420] A letter was sent to Mr. Barnes, president of the Associated Hospitals of Alberta [AHA], [421] regarding minimum salaries and hours of duty for nurses. At the AHA meeting in November 1944, the superintendents of nurses and matrons made a recommendation, approved by the general session, that a joint committee of the AARN and the AHA study minimum salaries and hours of duty. [422] When no action was taken an investigation showed that the minutes did not indicate that the recommendation had been passed. The AARN decided that a delegation should be sent to the next AHA executive meeting, and if no action was taken then, that the problem be referred to the Minister of Trade and Industry. "The action was deemed necessary because of the continued neglect of the A.H.A. to appoint a committee as requested by the A.A.R.N. to meet with the A.A.R.N. committee to discuss this problem." [423]

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[420] AARN. (August 12, 1944). Minutes. Edmonton, p. 564.

[421] This association resulted from the amalgamation of the Alberta Hospital Association and the Municipal Hospitals Association (AARN. (January 26, 1944). Minutes. Edmonton, p. 553).

[422] AARN. (January 20, 1945). Minutes. Edmonton, p. 566; AARN. (March 24, 1945). Minutes. Calgary, p. 569).

[423] AARN. (March 24, 1945). Minutes. Calgary, p. 569.

The meeting was eventually held on June 25, 1945. [424] In July 1945 groups of nurses met to discuss and formulate provincial employment policies which were then discussed with the AHA committee. Modifications were made regarding the number of increments and excluding the superintendents and assistant superintendents from the agreement. The policies were mailed by the AARN to all hospitals with an explanatory letter; the response was so poor that Dr. McGugan of the AHA recirculated the letter. [425]

In the meantime, Mr. C. W. Clement, legal counsel to the AARN, developed a statement regarding the Industrial Conciliation and Arbitration Act. This statement was included in information packages on bargaining agents that were sent to matrons and nursing superintendents of hospitals with more than one hundred beds. A second letter was sent to small hospital superintendents indicating the AARN would be willing to act as bargaining agents if disputes arose. [426] Esther Beith of the CNA

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[424] Kathleen Connor, Sister Herman, Barbara Beattie and Bell Rogers formed the AARN committee. The Registrar was to prepare for the meeting current salary schedules, room and board rates, superannuation schemes, and seek legal advice if necessary (AARN. (May 12, 1945). Minutes. Edmonton, p. 578). The AHA executive appointed a committee (Dr. A. C. McGugan of Edmonton, Mr. C. O. Savage of Raven, Sister Cohan of Vegreville, and Mr. N. McClellan of Vermilion as an alternative) to meet with the AARN committee by September 10, 1945 (AARN. (July 14, 1945). Minutes. Edmonton, p. 581).

[425] AARN. (October 26, 1945). Minutes. Edmonton, p. 585.

[426] AARN. (January 20, 1945). Minutes. Edmonton, p. 567. Kathleen Connor and Barbara Beattie were to be the AARN bargaining agents. (AARN. (May 12, 1945). Minutes. Edmonton, p. 579). Industrial nurses

asked to be kept informed about any problems arising and action taken related to labour relations, especially regarding the strike clause. [427] In 1946 she stated there were three opinions within the nursing profession regarding labour relations: (a) no association with trade unions because it would decrease the "prestige and strength of the professional association," (b) association with trade unions because the "professional association has failed nurses," and (c) association with the professional organization for collective bargaining. [428] One nurse from each district was to be included on the labour relations committee. [429] The suggested minimum salary of general duty nurses living "out" was $1200.00 the first year, $1260.00 the second, and $1320.00 the third year of service. The

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were surveyed about their salaries and hours of duty by the labour relations committee (AARN. (January 20, 1945). Minutes. Edmonton, p. 566). Office nurses were to come under the salary schedule controlled by the Regional War Labour Board (AARN. (March 24, 1945). Minutes. Calgary, p. 569).

[427] In 1946, Esther Beith presented at the AARN annual meeting an address titled, "Professional Labour Relations." One of her statements would probably have summed up the feelings of most nurses in the 1940s, "Some union practices are not possible for nurses--"strike" is one word that should be unknown in the nursing profession.

[428] AARN. (April 8-9, 1946). Minutes. Edmonton, p. 594; Kerr, M. (1946). Should we? The Canadian Nurse, 42, pp. 923-925; Triggs, F. O. (1946). Personnel practices in the nursing profession. The Canadian Nurse, 42, pp. 943-948.

[429] AARN. (March 26, 1945). Minutes. Calgary, p. 573. A detailed description of what kind of nurse was given in the motion: "mature, discreet, well informed, interested persons more or less permanent in the District" (AARN. (May 12, 1945). Minutes. Edmonton, p. 579).

hours of duty recommended were an eight hour day exclusive of meal hours, with a six day week. Hours were to be consecutive when possible. [430]

Although a war was ongoing, there were still local professional problems demanding the attention of the AARN council. As the AARN was responsible for ensuring that members conducted themselves professionally, they were required to investigate two incidents in September 1942: (a) a complaint regarding the conduct of nurses at Grande Prairie Municipal Hospital, [431] and (b) a complaint from the Department of Pensions and National Health regarding a nurse who had been convicted of illegal possession of narcotics. [432] On July 14, 1945, the AARN held its first court of enquiry with Mr. Clement's assistance. The nurse was found guilty of unprofessional conduct, her name "erased" from the register, and her certificate revoked. [433]

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[430] AARN. (March 26, 1945). Minutes. Calgary, pp. 575-576.

[431] There was no details in the minutes; the nurses and the complainants were notified and asked for further information. No further mention was made of this problem (AARN. (September 26, 1942). Minutes. Edmonton, p. 540).

[432] This nurse received a year suspension (AARN. (September 26, 1942). Minutes. Edmonton, p. 540). This case was discussed over the next two years (AARN. (January 26, 1944). Minutes. Edmonton, p. 555; AARN. (May 12, 1945). Minutes. Edmonton, p. 578-579).

[433] AARN. (May 12, 1945). Minutes. Edmonton, p. 578; AARN. (July 14, 1945). Minutes. Edmonton, p. 584. The nurse returned her certificate to the provincial office (AARN. (April 6, 1946). Minutes. Edmonton, p. 588).

The work related to post-war planning began in earnest in 1944. That year the Canadian Government passed the Department of National Health and Welfare Act. The minister was given the duties, powers, and functions for all matters related to promotion and preservation of health, social security, and social welfare. [434] The CNA had organized a national committee with provincial association representation to study post-war needs and the role which Canadian nurses would play collaboratively with other agencies and professions. The AARN sent some recommendations to Mrs. McWilliams of the Committee on Post-War Planning: Sub-Committee on Post-War Problems of Women. [435] Recommendations regarding training in nursing of honorably discharged members of the armed forces were developed by the superintendents of nursing schools in Alberta and sent to CNA. [436]

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[434] Dominion of Canada. (1952). Revised statutes of Canada. Ottawa: Author, pp. 2405-2408. More specifically the duties included: (a) "investigation and research into public health and welfare"; (b) medical care of immigrants and seamen; (c) administration of federal hospitals; (d) supervision of public health in all forms of transportation; (e) promotion and conservation of health of government employees; (f) international health related to Canada's foreign policy; (g) administration of the Food and Drug, Opium and Narcotic Drug, Quarantine, Public Works Health, Leprosy, Proprietary or Patent Medicine, National Physical Fitness Acts; (h) administration of Statistics Act in the areas that affect the health and lives of people; and (i) cooperation with provincial authorities in the coordination of public health, social security, and social welfare policies and programs.

[435] AARN. (March 31, 1944). Minutes. Edmonton, p. 559. This committee was formerly called the Committee of Reconstruction.

[436] AARN. (August 12, 1944). Minutes. Edmonton, p. 565; AARN. (March 24, 1945). Minutes. Calgary, p. 570. The recommendations

A number of new initiatives were taken by the AARN in 1945: (a) the first newsletter was sent out in September 1945 to 150 agencies, not to individual members; [437] (b) bargaining units were formed; [438] (c) the AARN requested that the UofA conduct laboratory studies on disinfectants and their proper use; [439] (d) the AARN protected the fee structure of the registered nurse in relation to the practical nurse; [440] (f) it made recommendations to the Department of Education in an effort to improve the quality of education of students entering nursing; [441]

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suggested that those without minimum entrance requirements take advantage of the federal educational program. Nurses with the required minimum education and able to present proof of instruction and ward experience during their service received a temporary permit and were allowed to take the last six months of the diploma program while being paid as general staff nurses (AARN. (August 12, 1944). Minutes. Edmonton, p. 563).

[437] AARN. (October 26, 1945). Minutes. Edmonton, p. 586.

[438] Employment policies were being developed by the AARN in collaboration with other groups: (a) general duty nurses with the AHA; (b) nurses in doctor's offices with the War Labour Board (AARN. (April 6, 1946). Minutes. Edmonton, p. 590); and (c) practical nurses with Women's Training Division of the Department of Labour of Ottawa.

[439] AARN. (October 26, 1945). Minutes. Edmonton, p. 587. This first step into research was stimulated by the lack of accurate knowledge by nurses writing RN examinations. Information to assist in this experiment was received from some of the larger hospitals (AARN. (April 6, 1946). Minutes. Edmonton, p. 589). Dr. Shaw, Provincial Bacteriologist, and Dr. Orr, Dean of Medicine were involved in the study (AARN. (August 30, 1946). Minutes. Edmonton, p. 609).

[440] A sample fee schedule for practical nurses was sent to hospitals (AARN. (October 26, 1945). Minutes. Edmonton, p. 587; AARN. (April 6, 1946). Minutes. Calgary, p. 589).

[441] Concerns voiced by the CNA as to the quality of spelling and math were sent to Dr. McNally the Alberta Deputy Minister of Education. These complaints were to be discussed at a curriculum committee (AARN.

(g) the AARN was beginning to analyze legislation and make recommendations to the government; [442] (h) the history of nursing of Alberta,"Collection of Facts-Alberta," was bound and sold; [443] and (i) the AARN legislation committee agreed to study the Woman's Charter submitted by the Canadian Women's National Organization. [444]

The amount of work accomplished by the AARN during the war years was possible because of the development of a number of committees. [445] The majority of the convenors were AARN

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(October 26, 1945). Minutes. Edmonton, p. 587). Interestingly, prior to this the AARN had sent suggestions through the UofA and received little satisfaction, especially in regard to the need for Chemistry laboratory experience in high schools.

[442] The increased interest of the AARN in the legislation was apparent when a motion was passed to subscribe to the Alberta Provincial Gazette (AARN. (May 12, 1945). Minutes. Edmonton, p. 579). The first instance of interest identified was in relation to the hospital act requirements for registered nurses (AARN. (October 26, 1945). Minutes. Edmonton, p. 587). A committee was convened by H. Peters to prepare a report on An Act to Provide Health Services for the People of Alberta (AARN. (April 6, 1946). Minutes. Edmonton, p. 590). An Act to Provide Health Services for the People of Alberta [The Alberta Health Insurance Act, 1946] was passed March 27, 1946 (Government of Alberta. (1946). Statutes of Alberta. Edmonton: Author, pp. 25-35).

[443] AARN. (July 14, 1945). Minutes. Edmonton, p. 583.

[444] AARN. (October 26, 1945). Minutes. Edmonton, p. 587. The findings of the AARN study were forwarded to the CNA with no information about content recorded in the minutes (AARN. (April 6, 1946). Minutes. Calgary, p. 589).

[445] In discussing the importance of committee work within the professional organization, Isabel Maitland Stewart stated:

> We need to work for the leadership of groups instead of individuals, the development of group thinking and action instead of domination by individuals no matter how able they may be. More wholesome for a profession to have many live, active members standing shoulder to

councillors. Most of the members of the committees were chosen by the convenors who tended to look for nurses with expertise and to provide for nursing representation from a number of districts and sections. The principles of democratic participation were being utilized by the leaders. [446] More nurses were being involved on committees and many seemed to be developing leadership qualities. The district concept appeared to stimulate involvement at the local and provincial level. The focus shifted from differences between nurses to their similarities, possibly arising from the need to help one another survive the depression and the horror of war.

During the first two years of the war, the AARN at times sacrificed its professional interests in favour of broader social interests: (a) it contributed money to the British Nurses' Relief Fund to help nurses, "who in any way became victims of air-raids and to help replace valuable hospital equipment damaged or

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shoulder and sharing democratically in the common effort than to have a few generals and a host of followers.
(Stewart, I. M. (no date). Unpublished notes of a talk on organization work, p. 3. (AN 2670))

[446] Lindeburgh, M. (1942). The fundamentals of professional leadership. Canadian Hospital, 19(6), pp. 19-21, 54, 56. "In the last analysis, the status of nursing, the achievements of nurses, their professional conduct, and their influence upon the public will be determined largely by the quantity and quality of the leadership which is provided" (p. 19); Kratz, A. H. (1940). For leadership. The American Journal of Nursing, 40, pp. 876-879; Kerr, M. E. (1946). The essence of leadership. The Canadian Nurse, 42, pp. 113-114.

destroyed"; [447] and (b) it invested $1000.00 in the victory war loan. [448] The CNA also contributed to the war effort when it made a gift of $4,500.00 for three mobile X-ray units in 1940. [449]

The AARN worked in collaboration [450] with a number of different organizations and professional groups during the war: (a) Women's Organization on Wartime Prices and Trade Board, [451] (b) Alberta emergency epidemic planning, [452] (c) Post-War

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[447] AARN. (January 11, 1941). Minutes. Edmonton, p. 521. This collection of funds took precedence over the Florence Nightingale Memorial Fund during the 1940s. By October 25, 1941 the AARN minutes recorded donations at $1,923.68. The Department of National War Services demanded that permits be attained by each provincial association to collect money for the Fund (AARN. (November 21, 1942). Minutes. Edmonton, p. 542). Following this notification, there was no more mention made of the fund until after the war.

[448] The AARN decided to do this instead of sending a representative to the CNA executive meeting June 2-3, 1941 (AARN. (May 17, 1941). Minutes. Edmonton, p. 527).

[449] AARN. (October 26, 1940). Minutes. Edmonton, p. 515; Johns, E. (1940). The time and place of meeting. The Canadian Nurse, 36, pp. 471-476.

[450] "We are assuming, of course, that the type of leadership of which we stand in great need at the moment, is not of the kind which is exercised by the autocrat or dictator" (Lindeburgh, M. (1942). The fundamentals of professional leadership. Canadian Hospital, 19(6), p. 19).

[451] A. E. Vango represented the AARN at the initial meeting of this group (AARN. (February 7, 1942). Minutes. Edmonton, p. 533).

[452] A list of nurses was developed who could organize classes for the public (AARN. (February 7, 1942). Minutes. Edmonton, p. 533). Plans were being made for disasters or large scale emergencies, particularly in the area of communicable diseases (AARN. (April 6-7, 1942). Minutes. Macdonald Hotel, Edmonton, pp. 534-535).

Reconstruction Committee, [453] (d) AHA, (e) Provincial Committee on Nutrition, [454] (f) National Selective Service Committee, [455] (g) Rehabilitation Welfare Centre, [456] and (h) Civil Service Commission of the Department of Veterans Affairs [DVA]. [457]

It seems evident that Rae Chittick and Ida Johnson, presidents of the AARN during the 1940s, brought a new style of leadership to the organization, there was a real difference in the tone of the meetings during their terms of office. There was concern shown for the membership and the external community both locally and globally. The AARN became more proactive and less isolationist. The AARN as an association seemed to have matured beyond an auxiliary or social group to a professional association with confidence in its skill and knowledge.

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[453] AARN. (January 26, 1944). Minutes. Edmonton, p. 553.

[454] Some of the conclusions of a dietary survey of Edmonton were startling: 40% of people got about three quarters of the nutrients they required and another 20% got less than one half. The mother was the worst fed member of the family while the best fed was the father, the wage earner. The study stated that people needed to be taught how best to use their food money (Hunter, G, & Pett, L. B. (1941). A dietary survey of Edmonton. Canadian Public Health Journal, 32, pp. 259-265).

[455] AARN. (January 20, 1945). Minutes. Edmonton, pp. 565-568.

[456] The AARN suggested a registered nurse, to whom all women interested in nursing could be referred, be appointed at each centre (AARN. (March 24, 1945). Minutes. Calgary, p. 571).

[457] The representatives appointed were Sister Herman to Calgary and Virginia Pearson to Edmonton (AARN. (May 12, 1945). Minutes. Edmonton, p. 579). Criteria for entrance into Training Schools of Nursing for ex-service personnel were made the same as the criteria set by the UofA for any other post secondary education (AARN. (August 30, 1946). Minutes. Edmonton, p. 601).

With the ending of the war old problems returned and others remained. As Dominion-Provincial grants were significantly decreased the AARN had to make some difficult decisions as to what it was able to finance. The publicity and student recruitment programs were discontinued and the number of short courses for graduate nurses had to be decreased. Unsuccessful attempts were made to acquire grants from the Alberta Department of Public Health. [458] One of the major concerns was to continue financing the Nurse Placement Service [NPS], which was crucial to ensuring quality nursing care to hospital patients and to ensuring sufficient work for registered nurses. [459] The AHA, hospitals, AARN and National Employment Service all saw a need for this type of agency but none were prepared or able to finance it completely. The AHA financed it for 1946. In 1947 the AARN assumed responsibility, however by April 1948 it was necessary to use funds from the savings account. Finally on

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[458] AARN. (April 6, 1946). Minutes. Edmonton, p. 592. Grants to help student nurses pay for the probationary period of training were continued by the Canadian Vocational Training Program [CVTP], however from 1946 to 1948 there were fewer applications. This was probably a reflection of the improved economy in Alberta. In 1949 eleven of the thirteen applicants were enrolled in Vegreville School of Nursing. Perhaps children of the Eastern Europeans immigrant population were now reaching the age to enter nursing and required financial assistance. Alternatively it could be that the Vegreville school of nursing was informing its students of how to attain grants. The applications were rejected by J. R. Ross of the CVTP. The AARN undertook to interview the applicants as Sister Boisseau stated that all needed the grant (AARN. (September 24, 1949). Minutes. Edmonton, p. 771).

[459] AARN. (April 6, 1946). Minutes. Edmonton, p. 588; AARN. (August 30, 1946). Minutes. Edmonton, p. 603.

November 1, 1948 the Unemployment Insurance Commission took the NPS over. [460]

The anticipated relief from the nursing shortage with the return of the armed forces nurses did not occur. [461] To help meet the nursing needs some hospital administrators hired graduate nurses not eligible for registration. [462] The Alberta government was putting pressure on the AARN to decrease entrance requirements as a way to help alleviate the nursing shortage. In April 1946 Gordon Taylor MLA for Drumheller publicly insisted that the Registered Nurse's Act be opened to alter the educational and registration requirements. Members of the AARN actively lobbied other MLAs, and in the Minutes of April 6, 1946 the results were recorded: "Activity ceased upon the Hon. Dr. Cross stating that the Act was not to be opened." [463] Despite this assurance, the AARN continued to be pressured to lower its

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[460] AARN. (January 16-17, 1948). Minutes. Edmonton, p. 698; AARN. (April 3, 1948). Minutes. Edmonton, pp. 711-712; AARN. (September 25, 1948). Minutes. Edmonton, p. 731.

[461] Approximately four thousand nurses were in the Canadian armed forces; only sixty were from Alberta. The death of one nurse was reported during the war (CNA. (1968). The leaf and the lamp. Ottawa: Author).

[462] Graduate nurses of long standing without present required academic qualifications were given the opportunity to challenge the registration [RN] examinations (AARN. (August 30, 1946). Minutes. Edmonton, p. 613).

[463] AARN. (April 6, 1946). Minutes. Edmonton, p. 589.

educational standards. At its November, 1946 meeting the AARN agreed to the following resolution:

> The final consensus of opinion of the Council members, considering the political pressure; the fact that our Act may be opened by the Legislature at the 1947 session and the fact that our present minimum academic requirements do not permit acceptance into any University in Canada, was that we should accept the Grade XI standard as arranged by the Academic Revision Committee. It was decided that the minimum grading requirement should be stated as at least 50%, not a "B" standing. [464]

As both the AARN and the Minister of Public Health had received criticisms concerning schools of nursing, there was a need for school inspections to be reinstated. The AARN had requested funding for nursing advisors to work with hospitals and schools of nursing to ensure the maintenance of educational standards. Dr. Cross refused the funding on the basis that the UofA was responsible for inspection of schools of nursing. [465] The Canadian government was also pressuring the AARN. They wanted the AARN to consider plans to train women discharged from the armed services as subsidiary workers. [466]

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[464] AARN. (November 5, 1946). Minutes. Calgary, p. 619. Rae Chittick was specifically mentioned as objecting to the lowering of standards. The minutes stated she left the meeting at the end of this discussion (AARN. (November 5, 1946). Minutes. Calgary, pp. 618-620).

[465] AARN. (April 6, 1946). Minutes. Edmonton, pp. 591-592; AARN. (April 17, 1947). Minutes. Calgary, p. 655.

[466] AARN. (July 14, 1945). Minutes. Edmonton, p. 583. The request made in July was for approval of a plan for training subsidiary workers. It was decided to create a study group to look at a "Total Nurse Practice Act for Alberta." which would include subsidiary workers. The Canadian Vocational Training [CVT] program for practical nurses started in January,

Tension was increasing between the AARN and the AHA regarding salaries, hours, living and working conditions of general duty nurses. [467] The 1946 annual meeting discussed in some detail labour relations and in particular how to avoid "unpleasant disputes" and make possible the "settlement of disputes on a basis of goodwill without reverting to the formation and legal certification of a negotiating or bargaining group." Not all nurses apparently supported this view, as a resolution was presented by the General Nursing Section "That an attempt be made to stabilize the minimum salary for general duty personnel rather than depend on a goodwill policy." The motion was tabled by the general meeting. Another resolution presented by the UofA Hospital Alumnae Association emphasized that even though employment opportunities for nurses were good there was no guarantee of work, therefore "whereas goodwill alone on the part of both the employers and employees has been unable to prevent such a fall in wages in the past" agreements must be made in writing and the AARN should encourage this practice. [468] This resolution was defeated with a show of hands.

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1946. Miss Graham, supervisor of women's training, Department of Labour in Ottawa asked the AARN: (a) to approve the course content, (b) to be part of an advisory committee, and (c) to provide information regarding legislation related to practical nurses (AARN. (April 6, 1946). Minutes. Calgary, p. 588). The AARN sent recommendations. (AARN. (August 30, 1946). Minutes. Edmonton, p. 599).

[467] AARN. (August 30, 1946). Minutes. Edmonton, p. 598.

[468] AARN. (April 8-9, 1946). Minutes. Edmonton, pp. 594-596.

In the end, the legislation and labour relations committees were asked to study the Alberta Industrial Conciliation and Arbitration Act and inform the AARN membership as to the proper procedure. There would seem to be a growing tension around the issue of collective bargaining within the membership of the AARN. The tension was perhaps partially due to two concerns: (a) the differing opinions as to how best improve the living and working conditions of nurses and still remain congruent with the service ideal, and (b) the fear of loss of control by the AARN, a relatively young professional association, to an outside group, a trade union. [469]

The August 1946 the AARN council meeting revised the standing committees. [470] The AARN committees that continued included: [471] (a) The Canadian Nurse Committee, [472]

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[469] A federal bill concerning industrial relations and disputes investigations caused concern within the CNA and the AARN because the nurses, if included, would be considered a trade, and if excluded, would be deprived of the right to collective bargain. Doctors and dentists had obtained exemptions (AARN. (January 16-17, 1948). Minutes. Edmonton, p. 701). A report at the September meeting in 1948 stated that the CNA had decided against obtaining an exemption from the National Labour Code (AARN (September 25, 1948). Minutes. Edmonton, p. 738). The Alberta Labour Act was passed in 1947 (Government of Alberta. (1955). Revised Statutes of Alberta. Edmonton: Author, Chapter 167).

[470] Committees concerned with hours of duty, bursary awards, nutrition, post-war planning and school of nursing records were discontinued.

[471] AARN. (August 30, 1946). Minutes. Edmonton, pp. 602-608.

[472] AARN. (August 30, 1946). Minutes. Edmonton, p. 605. Subscriptions in 1944 had increased across Canada by 60%.

(b) Subsidiary Workers Committee, [473] (c) Health Insurance Committee, [474] (d) Instructors' group report Committee, [475] (e) Nursing Placement Service Committee [NPS], (f) War Labour Board Committee, (g) Total Nurse Practice Act Committee, (h) Legislation Committee, and (i) Labour Relations Committee.

New committees were created to meet new needs identified by the AARN. The Educational Policy Committee was struck to examine ways to include tuberculosis, psychiatry and rural hospital nursing in nursing courses to ensure new graduates would be completely prepared for these challenges. [476] Helen

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[473] AARN. (August 30, 1946). Minutes. Edmonton, p. 606. The AARN moved from a position of opposition, to neutrality, to open support for the Calgary practical nurse training course. Committee recommendations to the AARN were the following: (a) civilians to be included in the program, (b) approval of trained subsidiary workers being employed in the hospital and home, (c) a Total Nurse Practice Act be ready for the 1948 legislature, (d) new facilities should not be established by the instructors, rather the government should provide practice facilities, and (e) that some Municipal Hospitals be used for practical experience. These recommendations, approved by the AARN and sent to Mr. Ross, director of the CVT, established a good working relationship between the nursing aid program and the AARN that lasted throughout the 1940s. (AARN. (November 5, 1946). Minutes. Calgary, p. 617). The name of this committee was changed to Auxiliary Workers' Committee to be congruent with terms used by the CNA (AARN. (September 25, 1948). Minutes. Edmonton, p. 731; Parker, M. L. (1946). Training auxiliary workers. The Canadian Nurse, 42, pp. 563-566).

[474] AARN. (August 30, 1946). Minutes. Edmonton, p. 602. Dr. Cross was asked to include an AARN representative on the Advisory Committee. The AARN membership studied the act at district meetings and the committee wrote a brief for council (AARN. (November 5, 1946). Minutes. Calgary, pp. 617-618 ).

[475] AARN. (August 30, 1946). Minutes. Edmonton, p. 602. This committee was responsible for revisions to the standard curriculum.

[476] AARN. (August 30, 1946). Minutes. Edmonton, p. 599; AARN. (February 1, 1947). Minutes. Edmonton, p. 636; Keeler, H. B. (1946).

Penhale, convenor of the Library Committee, was to make an inventory of books and to suggest new books to buy so that nursing students and AARN members would have access to current health information. [477]

By 1947 the AARN staff included three full-time and one part-time member. [478] This increase in staff made it necessary to find new office space. [479] The AARN provided its employees yearly salary reviews, sick leave, vacation leave, cost of living bonuses and superannuation programs. [480]

In 1946 the AARN appeared to be losing control of the nursing profession. Not only had the council yielded to the pressure exerted by the Alberta government and significantly lowered the minimum entrance requirements for schools of

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Preparing the nurse for present day responsibilities. The Canadian Nurse, 42, pp. 873-876; AARN. (September 25, 1948). Minutes. Edmonton, p. 745.

[477] AARN. (November 5, 1946). Minutes. Calgary, p. 627. The library was housed and cared for by the UofA school of nursing. To encourage library use, regulations were printed on active membership cards and new books were listed in the newsletter (AARN. (April 3, 1948). Minutes. Edmonton, p. 711).

[478] In addition to the registrar/secretary, Bell Rogers, the stenographer-bookkeeper/treasurer, Ruth Corbett, and the director of NPS, M. Cogswell, a part time clerical person was hired (AARN. (April 17, 1947). Minutes. Calgary, p. 654). By 1948 the clerical position was full-time.

[479] AARN. (April 17, 1947). Minutes. Calgary, p. 658. The office was moved to an unnamed location (AARN. (September 6, 1947). Minutes. Edmonton, p. 682). The AARN office was moved again in 1948 (September 25, 1948). Minutes. Edmonton, p. 745).

[480] AARN. (January 16-17, 1948). Minutes. Edmonton, p. 700; AARN. (September 25, 1948). Minutes. Edmonton, pp. 733-735.

nursing, but when Bell Rogers met with Dr. Cross to discuss the academic revisions she had to endure the further humiliation of being told by a medical professional that the criteria had "already been decided in caucus." After much discussion a few changes were made to the government's criteria. [481]

In 1947 an incident involving the UofA caused the AARN concern with regard to control of the profession. Dr. Newton changed the past informal procedure related to the appointment of the RN examining panel at the UofA to fit the more formal university methods. [482] The problem became magnified when, after meeting with H. Penhale, M. Cogswell and B. Rogers to prepare such a list, Dr. Ower, Dean of Medicine, unilaterally created the board before the list could be approved by the AARN.

A request for written clarification of the relationship between the UofA and AARN brought a detailed reply from Dr.

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[481] AARN. (February 1, 1947). Minutes. Edmonton, p. 632. The meeting took place on December 5, 1946. Interestingly the government had set the credits at 67 with not less than "B" standing! Revisions included changing Physics I to Physics I or Biology I and the addition of 2 units of a foreign language. The act to amend The Registered Nurses Act was assented to March 21, 1947 (Government of Alberta. (1947). Statutes of Alberta. Edmonton: Author, p. 387). Another amendment on March 31, 1948 stipulated that Grade XI was necessary (Government of Alberta. (1948). Statutes of Alberta. Edmonton: Author, pp. 377-379).

[482] Dr. Newton notified the registrar that neither the University Act or the Registered Nurses Act provided a mechanism to set the board, therefore the AARN was to make a list from which the Faculty of Medicine would select a board to be appointed by the General Faculty Council. He requested that the Director of the School of Nursing, UofA be included on the list (AARN. (February 1, 1947). Minutes. Edmonton, p. 633).

Newton. [483] Although in theory procedures and professional relationships may not have been much different from before, they had changed significantly in practice. Where once the relationship had been informal and built on professional courtesy, it was now formal and built on bureaucratic "redtape." [484] In September, 1947 the AARN was notified that marks would no longer be issued for licensing exams. [485] The UofA was quite stringent in their equivalency criteria for enabling certificates, and often people were denied reciprocal registration that the AARN would have approved. In some situations an explanation was made by the AARN and the applications were resubmitted for assessment. If they were rejected occasionally the AARN

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[483] AARN. (February 1, 1947). Minutes. Calgary, pp. 633-635. Unlike the past experience of the AARN, now the nurse advisor for schools of nursing was seen by the Minister of Health and the UofA President as being the complete responsibility of the UofA. The relationship of the nurse advisor to the AARN was explicitly stated: "It would not appear that the advisor as a member of the University staff would have any official relationship to the A.A.R.N., but the University would expect her to maintain close, if informal, relationships with the Nurses Association."

[484] The lines of communication in the UofA were designated as being through the president, not the registrar as had been the case when Mr. Ottwell had been living (AARN. (August 30, 1947). Minutes. Calgary, p. 601). The AARN was invited to name a representative to the University School of Nursing. The General Faculty Council was the only body having jurisdiction over standards and examinations of the professions. No mention was made of a representative on the UofA senate as had always been the practice.

[485] AARN. (September 6, 1947). Minutes. Edmonton, p. 682. Pass or fail marks would be given as was the policy for other licensing examinations. The UofA registrar asked the advice of the AARN as to the pass mark. The AARN recommended 40%, like the Department of Education.

overrode the decision by granting full registration. [486] By 1948 the AARN was attempting new approaches to regain control of registration of nurses.

While the Educational Policy Committee continued to examine the idea of a central school of diploma nursing in Calgary, possibly under the direction of UofA, [487] another disconcerting event occurred in 1947. The Minster of Health had asked the UofA, rather than the AARN, to inspect hospitals at Grande Prairie, Red Deer, Drumheller, Westlock, and Lethbridge with the idea of opening schools of nursing. According to Helen Penhale, the AARN was to be asked to provide a representative on the committee. This request for a representative finally came and in June, Bell Rogers assisted in the evaluation of the two Lethbridge hospitals. [488]

The idea of practical nurses being included under a "Total Nurse Practice Act" was taken out of the hands of the AARN when Dr. Cross took the initiative and formed a committee which included the Medical Inspector of Alberta hospitals as the convenor, the Director of Department of Health Services and representatives from AARN, AHA, and CVT to study the

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[486] AARN. (April 3, 1948). Minutes. Edmonton, p. 714.

[487] AARN. (February 1, 1947). Minutes. Edmonton, p. 636.

[488] AARN. (February 1, 1947). Minutes. Edmonton, p. 633; AARN. (April 17, 1947). Minutes. Calgary, p. 659; AARN. (September 6, 1947). Minutes. Edmonton, p. 680.

"examination, training, licensing, and regulation of nursing aides in the Province of Alberta." [489]

The years 1946 and 1947 were difficult for the AARN. In 1946 a number of resignations [490] were submitted, which disturbed the continuity of the council and some of the

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[489] AARN. (November 5, 1946). Minutes. Calgary, p. 621. It was decided that: (a) the name would be "nursing aides," (b) the minimum entrance qualifications would be Grade IX and 18 years of age, (c) the AARN would be responsible to outline the curriculum, and (d) the Attorney General's Department would draft a Bill for nursing aides in Alberta (AARN. (February 1, 1947). Minutes. Edmonton, pp. 640-641). The Nursing Aides Act was assented to in 1947 (Government of Alberta. (1955). Revised statutes of Alberta. Edmonton: Author, pp. 3565-3568).

The advisory board included the medical inspector of hospitals, superintendent of public health nursing branch, a representative of the AHA, AARN, Vocational Training Advisory Council, licensed nursing aides. The first registrar-consultant provided for in the act was Francis Ferguson. She was also second vice-president of the AARN 1947-1949 (AARN. (January 16-17, 1948). Minutes. Edmonton, pp. 699, 701). Examinations were being held in Calgary and Edmonton for practical nurse applicants to become certified as nursing aides. The nursing aides had the benefit of the experience of the registered nurses on the advisory committee when it came to the development of their educational programs, salary, fees, and certification (AARN. (April 3, 1948). Minutes. Edmonton, p. 710).

[490] Most of the resignations were from people that had provided leadership during the war: (a) Helen McArthur resigned to become director of nursing service for the Canadian Red Cross (Editor. (1947). Alberta department of health. The Canadian Nurse, 43, pp. 70; AARN. (August 30, 1946). Minutes. Calgary, p. 610); (b) Helen Peters resigned as chairperson of the legislation committee (AARN. (November 5, 1946). Minutes. Calgary, p. 622); (c) Miss Reesor submitted her resignation as the AARN representative to *The Canadian Nurse* committee (AARN. (November 5, 1946). Minutes. Calgary, p. 616; AARN. (February 1, 1946). Minutes. Calgary, p. 630); (d) Ruth Gavin resigned as stenographer/AARN treasurer (AARN. (April 6, 1946). Minutes. Calgary, p. 592); (e) Virginia Pearson retired at the end of 1946 from active membership in the AARN (AARN. (November 5, 1946). Minutes. Calgary, p. 618); (f) Bell Rogers resigned to go to Toronto, however, she continued in her position until 1949 (AARN. (November 5, 1946). Minutes. Calgary, p. 627). She then accepted the position of Director, School of Nursing, General Hospital St. Catherines, Ontario and Mrs. C. Van Dusen became registrar (AARN. (April 28, 1949). Minutes. Calgary, p. 748).

committees. The committee structure, which during the war years appeared to create unity, common vision, creative thinking and action, seemed to create an atmosphere of fragmentation, confusion, conservative thinking and hesitant action in the post war years. Prior to 1946, the president led the meetings and the council worked as a unit to make plans on issues. The registrar acted as an advisor and coordinator and was infrequently mentioned in the minutes. During 1946, the registrar was made an ex-officio member of each committee and convenor of some committees. She became a major participant at the council meetings. The transition from volunteer direction, where the council was a working board, to more of a corporate model, where the council would be a policy making board would seem to have begun.

Rae Chittick was president of CNA from 1946 to 1948. [491] The CNA was involved in two major collaborative initiatives in 1946 studying ways to decrease the nursing shortage. Ethel Johns prepared a submission on nursing service in Canada for the Inter-departmental Committee on Professionally Trained People. [492] Representatives of the CNA, Canadian Hospital Council [CHC], CMA, DVA, and Department of Health and Welfare formed a

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[491] Editor. (1946). Our new president. The Canadian Nurse, 42, p. 649.

[492] CNA. (1968). The leaf and the lamp. Ottawa: Author, p. 89. Ethel Johns was replaced by Margaret Kerr as editor of The Canadian Nurse on May 1, 1944 (Lindeburgh, M. (1944). The new editor of the journal. The

joint committee to assess the acute shortage of hospital nursing staff in relation to the hospital expansion. [493] In 1947, after a long struggle, the CNA became incorporated under the statutes of Canada. [494]

In 1948 the twenty-ninth annual meeting of the AARN was attended by 137 members. Discussions as to how to improve the AARN's financial status led to the opinion that the annual professional fee was very low at $5.00. It was noted that rather than increasing it each year by a little, it might be preferable to make a significant increase once. All but three nurses from Calgary supported an increase in professional fees to $8.00. [495] Revisions were made to the bylaws which increased the AARN council by two, another councillor and the past-president. The revisions related to districts, chapters, and committee structure

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Canadian Nurse, 40, p. 310; Editor. (1944). An expression of appreciation. The Canadian Nurse, 40, pp. 468-469).

[493] Fanny Munroe was the chairperson of this joint committee from 1946 to 1948. For a detailed account of the meetings of this committee check Hall, G. M. (1948). Joint committee--1946-1948. The Canadian Nurse, 44, pp. 472-475. AARN. (November 5, 1946). Minutes. Calgary, p. 616.

[494] An act to incorporate the Canadian Nurses' Association was assented to June 27, 1947 (Government of Canada. (1947). Statutes of Canada. Ottawa: Author, pp. 43-47). Of the ten names listed three had been a major influence in the AARN: Rae Chittick, Fanny Munroe, and Agnes Macleod.

[495] AARN. (April 5-6, 1948). Minutes. Edmonton, pp. 720, 724. Nurses from Calgary felt non-practising or associate members' privileges were "too extensive, and the that Associate members should not have the right to vote and hold office" when the fee was only one dollar (AARN. (April 5-6, 1948). Minutes. Edmonton, p. 725).

simplified and standardized the organization. It was reported that more hospitals had adopted the 48 hour week and the average salary of a general duty nurse was $110.00 per month plus maintenance. The fee for private duty nurses had increased to $6.00 for an eight hour day. [496] Beginning March 1948, a newsletter was to be printed quarterly and a copy sent to each active member of the AARN. [497] No grants were voted by the legislature for the AARN, however the association decided to ask the Department of Health for further funding. [498]

Relations between the AHA and the AARN seemed to improve dramatically in September 1947. The AHA invited the AARN to appoint a representative as a non-voting member to attend AHA executive meetings if the AARN would extend the same privilege to the AHA. The invitation was accepted and extended to the AHA. [499] AHA representatives, Mr. Gallant (president) and Mr. Adshead (secretary) joined the January 1948 meeting to discuss common concerns: nursing aides, nursing placement service and nursing advisors for small hospitals. [500] Only the topics

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[496] AARN. (April 18-19, 1947). Minutes. Calgary, pp. 666-674.

[497] AARN. (January 16-17, 1948). Minutes. Edmonton, p. 693.

[498] AARN. (September 6, 1947). Minutes. Edmonton, p. 679.

[499] *Ibid.*, p. 689.

[500] AARN. (April 3, 1948). Minutes. Edmonton, p. 707. The AHA executive recommended to the Minister of Health that one or two nursing advisors be appointed. It decided if there was no government action on this resolution that it would be presented at the AHA annual meeting for further action by member hospitals.

discussed were included in the minutes, not the nature of the discussions. [501]

Personnel policies for nurses in Alberta hospitals were finalized by the AARN and AHA in February 1948 and distributed by the AHA in July. [502] The AARN approved an increase to seven dollars per eight hour day for registered nurses working in private duty. Nurses without registration would receive $6.00 per day. As of September 24, 1948 active registration stood at 2050 and the assets of the AARN were increasing slowly. The AARN was again taking a more assertive role with the UofA when it decided to suggest names for the Board of Examiners in Nursing, "in order that the membership would be stable and well informed in nursing matters." However once again the university reminded the AARN of its place. Helen Penhale reported that the

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[501] AARN. (January 16-17, 1948). Minutes. Edmonton, pp. 698, 702. Since the new executive elected in 1947 the minutes became brief and less informative, often written in point form and frequently no report was listed by the committee name in the minutes. It would seem that written reports were being submitted, however, none of these were located in the archives of the AARN (AARN. (April 3, 1948). Minutes. Edmonton, p. 708). The minutes refer to another file, "'Studies and Reports'-paragraph 7, CNA directive." A. Anderson, convenor of the institutional nursing committee asked about "accumulative correspondence" and "it was decided that reports dating back three or four years should be retained, as well as anything of historical value"! (AARN. (April 28, 1949). Minutes. Calgary, p. 748).

[502] AARN. (September 25, 1948). Minutes. Edmonton, pp. 731-741. Present board had included the following, all from the UofA: Dr. Newton (president), G. B. Taylor (registrar), Dr. R. Shaw, and Helen Penhale. The outside member was Sister Clermont (Vegreville General Hospital).

Board of Examiners was appointed by, and only responsible to, the UofA. [503]

As the AARN was receiving a number of complaints about the conduct of nurses, Bell Rogers recommended the formation of a Disciplinary Committee. It was decided by the AARN that there was no need for this kind of committee. The registrar was assured that if she needed help the Edmonton council members would be willing to assist her. [504] This gave the registrar another responsibility that had once belonged to the council members.

The planning committee for the thirtieth annual meeting of the AARN chose speakers that would be of interest to nurses working in all areas. [505] Opportunities were provided for nurses to learn about the roles of other professionals and also about new technology and drugs. [506] In the interest of nurses' welfare, Dr.

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[503] AARN. (April 28, 1949). Minutes. Calgary, p. 747.

[504] AARN. (April 3, 1948). Minutes. Edmonton, p. 711.

[505] AARN. (April 5-6, 1948). Minutes. Edmonton, pp. 719-722. Psychometric testing of students was presented by Mrs. Street. Augusta Evans discussed personnel counselling and guidance. Laura Graham compared nursing in New Zealand with Canada and Mary Dunn described nursing in displaced persons' camps. The districts were encouraged to bring in speakers and discuss issues pertinent to nurses of all sections.

[506] AARN. (April 5-6, 1948). Minutes. Edmonton, pp. 719-722. A panel discussed social welfare and occupational therapy in relation to psychosomatic medicine. A pharmacist, Miss Wholey, presented a paper on new drugs. Other presentations included were: new sterilization methods in central supply room units, newer methods in anesthesia, and the RH factor.

Bramley-Moore, registrar of the College of Physicians and Surgeons discussed prepaid medical plans. The council appointed the finance committee and registrar to study the possibility of group coverage for AARN members. [507] The membership decided to subsidize the expenses of two members from each district, so they could attend AARN general meetings. [508] Districts without registries requested the same per capita grant in order to assist with members' expenses to district meetings, and thereby, "secure a better informed and more interested District membership." [509]

For the first time in years, all schools of nursing in the province had accepted their quota of students, with many applicants having to be rejected. In 1948 the CNA requested a division of nursing in the Department of Health and Welfare and requested that the federal government require the provincial

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[507] AARN. (April 6, 1948). Minutes. Edmonton, p. 730. In 1947 the AARN had examined medical plans and decided not to become involved (AARN. (April 17, 1947). Minutes. Calgary, p. 659; AARN. (September 6, 1947). Minutes. Edmonton, p. 679).

[508] AARN. (September 24, 1949). Minutes. Edmonton, p. 771. This decision developed out of a resolution from the North Peace River Chapter (AARN. (April 3, 1948). Minutes. Edmonton, p. 713). There was a complaint from one district that this was unfair so more explicit allowances were outlined by the AARN and that only one delegate receive the allowance.

[509] AARN. (April 5-6, 1948). Minutes. Edmonton, p. 720.

governments to expend a certain portion of their budget on conserving and augmenting nursing service. [510]

Blanche Emerson stressed three important points in her inaugural presidential address in 1947: (a) nurses world-wide had the same nursing problems, (b) hospitals were being built without adequate numbers of nurses to staff them, [511] and (c) nurses' educational costs were being paid primarily by the sick in hospitals rather than with general public funds. [512] The AARN adopted a resolution recommending the UofA arrange for students living in Calgary and Southern Alberta to take the first year of the degree course in nursing using the facilities of the Faculty of Education, Calgary Branch. [513] In 1949, Rae Chittick,

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[510] AARN. (September 25, 1948). Minutes. Edmonton, p. 742. Dominion- Provincial health survey report made suggestions to the AARN: (a) try through publicity to "dispel the popular idea that hospitals exploit students"; (b) publicize the nursing aide program; (c) arrange affiliations with tuberculosis, psychiatry, and rural hospital nursing; and (d) study central schools and the training of male nurses. The survey committee for Alberta included: Dr. Somerville, Mr. McGilp, Jean Clark, plus five representative members and the liaison committees of the AARN, AHA, College of Physicians and Surgeons and Alberta Dental Association. The AARN formed a liaison committee.

[511] Learmonth, G. E. (1945). Alberta. The Canadian Medical Association Journal, 53, p. 91; Coppock, F. H. (1945). Small hospital construction. The Canadian Medical Association Journal, 53, p. 216-221. Five new hospitals were built in 1945 (Learmonth, G. E. (1945). Alberta. The Canadian Medical Association Journal, 53, p. 301). Alberta Department of Health expenditures for the year ending March 31, 1945 totaled approximately two and a half million dollars (Learmonth, G. E. (1945). Alberta. The Canadian Medical Association Journal, 53, p. 615).

[512] Cody, H. J. (1940). The contribution a hospital may make to its community. Canadian Hospital, 17(1), pp. 11-14. "The hospital must ultimately become the responsibility of the public as a whole" (p. 14).

[513] AARN. (April 30, 1949). Minutes. Edmonton, p. 769.

then associate professor of nursing education at the UofA, conducted the first extensive survey of nursing resources and nursing needs for Alberta. Her findings indicated that Alberta had one nurse to every 396 persons; the Canadian average was one to 336. The eleven training schools graduated 350 students annually. Fifteen to twenty percent were lost immediately upon graduation, usually to marriage. Alberta was short about 486 nurses at the time of the study. When the additional hospital beds being constructed were included in the estimate Alberta was short 958 nurses. [514]

With the influx of immigrants to Alberta, the AARN was beginning to receive more requests for registration from foreign trained nurses. [515] In 1948 the number of nurses requesting

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[514] AARN. (September 24, 1949). Minutes. Edmonton, p. 777; Chittick, R. (1949). A study of nursing services in Alberta. Edmonton: Government of Alberta. The recommendations included the following: (a) refresher or short courses organized regularly, (b) compulsory licensing for all nursing personnel, professional and auxiliary, (c) educational grants to approved hospitals, (d) study conducted regarding curriculum and methods of educating student nurses, (e) an advisor to schools of nursing and an advisor to hospitals without schools of nursing, (f) provide non-nursing personnel to do non-nursing work in the hospitals, (g) nursing staff stabilized through establishing sound personnel policies and comfortable and attractive living accommodations, (h) grants available to build and enlarge nurses' residences, (i) increased numbers of registered and auxiliary nursing personnel educated, (j) all nursing students affiliated with tuberculosis, psychiatry, rural hospitals and public health, (k) a central school established, (l) provincial bursaries available for students, and (m) a public relations program established at the junior high level to attract women into nursing.

[515] AARN. (January 16-17, 1948). Minutes. Edmonton, p. 694; AARN. (April 3, 1948). Minutes. Edmonton, pp. 714-715.

reciprocal registration increased significantly to twenty-seven: four were classified as foreign trained and two as displaced persons. [516] The AARN was aware that, "The general policy decided upon by the Department of Labour and the Canadian Nurses' Association was that the privilege of provincial registration should be extended to displaced nurses at the end of one year of service or earlier on the recommendation of the Director of Nurses in the employing hospital." However it continued to use the usual requirements while it examined the possibility of these nurses writing comprehensive examinations. [517]

By the 1940s the AARN had inherited all of the responsibilities of a professional association and was discharging them with energy. However, its effectiveness in influencing health care services and health policy was not reflective of its efforts.

Health Care Services and Health Policy

The ideas presented in the Alberta Bill of Rights Act passed March 27, 1946 provided insight into the rights of human beings as seen by a majority of Albertans:

> All men would have an opportunity to enjoy a free and abundant life including a measure of social and economic security....The discharge of the Province's responsibility

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[516] AARN. (September 25, 1948). Minutes. Edmonton, p. 743.

[517] AARN. (September 24, 1949). Minutes. Edmonton, p. 777.

> necessitates the recognition of certain basic rights and responsibilities of citizenship and requires that its citizens have the necessary access to their resources so that they may produce the goods and services they require and provide for their equitable distribution in a manner that will ensure to all an opportunity to obtain social and economic security with personal freedom. [518]

In 1948 Paul Martin, then Minister of the Department of Health, appeared to concur with the idea that human beings have the right to attain "a good life" and the political right to create societies for the "common good":

> In the wider comprehension of health as one of the fundamental rights of every human being, there can be no greater goal for national cooperative effort and the expenditure of the nation's financial resources, than to build the health of its citizens. The Government of Canada holds a democratic mandate and...is responding in democratic fashion to the people's will. [519]

C. E. Dolman provided a holistic definition of health in an article he wrote:

> Health is a relative term, comprehending not merely the physical welfare of man, but also his mental powers, and his moral and spiritual attainments. Hence it would be folly,...to

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[518] Government of Alberta. (1946). Statutes of Alberta. Edmonton: Author, p. 201.

[519] Martin, P. (1948). A national health program for Canada. Canadian Public Health Journal, 39, p. 226. In 1941, J. McCann, Minister of Pensions and National Health stated:

> It is the emphatic will of our Canadian people, expressed throughout our whole democratic system of government, that the care of the public health shall be a first concern of government. Our right to conduct our affairs with a primary regard for the health and welfare of our people is the very thing for which we have gone to war.

(McCann, J. J. (1941). Canada's war effort for the health of her people. Canadian Public Health Journal, 32, p. 588)

attempt a detailed assessment of the health of a nation such as Canada, with its many diversities of climate, race, custom and religion. [520]

A national physical fitness program [521] and a national nutrition program were developed in the hopes of improving the health of Canadians. [522] The need for war supplies led to the need to look into the health conditions of workers in factories so that there could be optimum productivity. [523] A great deal of health information was collected through the initial and subsequent medicals of young men enlisting in the armed forces. Reports regarding the appalling number of men that were rejected because of poor health led to increased interest in causes of poor health by health personnel and governments. [524] Surgical and medical

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[520] Dolman, C. E. (1941). The health of the nation. Canadian Public Health Journal, 32, pp. 387-403.

[521] The National Physical Fitness Act was passed in the 1943-1944 sitting of the parliament (Government of Canada. (1952). Revised Statutes of Canada. Ottawa: Author, pp. 4031-4034).

[522] Prett, L.B. (1943). Applied nutrition. Canadian Public Health Journal, 34, pp. 1-5; Prett, L.B. (1943). Educational techniques for nutrition. Canadian Public Health Journal, 34, pp. 58-61; Haegerty, J. J. (1943). The national physical fitness act. Canadian Public Health Journal, 34, pp. 465-469. In 1944 the Canada's food rules were first adopted (Canadian Council on Nutrition. (1949). A new dietary standard for Canada, 1949. Canadian Public Health Journal, 40, pp. 420-426.

[523] Editor. (1941). Lines of defence...and of offence. The Canadian Medical Association Journal, 43, pp. 402-403. "Our association is concerning itself with Industrial Medicine under war demands, and a draft syllabus has already been drawn up."

[524] Routley, T. C. (1941). More man power. The Canadian Medical Association Journal, 45, pp. 550-1. Forty per cent of the men were found to have disabilities that removed them from the top classification. Thirteen per cent of these men with an average age of 22.5 years were totally

treatments were constantly being researched during the war utilizing the large sample size that could be frequently documented over an extended period. [525] The effect of antibiotics on infectious diseases was documented. [526] Dr. Macdonald envisioned the hospital of the future as:

> A community health centre that will not only be responsible for therapeutic or curative medicine but will indeed pay as

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rejected for medical service; Pedley, F. G. (1945). Wartime health and education. The Canadian Medical Association Journal, 53, p. 72; Chittick, R. (1944). Weighed and found wanting. The Canadian Nurse, 40, pp. 557-560.

525 Research was reported on gastrointestinal disturbances and treatment on wounds and fractures (Editor. (1941). The war. The Canadian Medical Association Journal, 44, p. 417); Papers were also prepared by armed forces medical personnel on treating of acute retrocalcaneobursitis, brain abscesses, gas victims and the use of blood transfusions (Editor. (1941). The war. The Canadian Medical Association Journal, 44, p. 417); Gorssline, R. M. (1942). The medical services and the war. The Canadian Medical Association Journal, 47, pp. 116-119; Editor. (1943). Teaching of first aid. The Canadian Medical Association Journal, 48, p. 351; LaCroix, J. R. (1944). The management of wounds. The Canadian Medical Association Journal, 50, pp. 165-166; Wilson, R. A. (1946). Circumcision and venereal disease. The Canadian Medical Association Journal, 55, pp. 54-56; Dearden, A. F. (1943). An operating room set-up for plastic surgery. The Canadian Nurse, 39, p. 109.

526 The author referred to the use of the sulfanilamide group of medications in treating pneumonia (Editor. (1941). Health in Canada in 1941. The Canadian Medical Association Journal, 44, p. 162); Wightman, K. J. R. (1942). Chemotherapy with sulphonamide drugs. The Canadian Nurse, 38, pp. 835; Sinclair, C. (1943). History of sulphonamides. The Canadian Nurse, 39, pp. 676-677; Fisher, T. L. (1944). Newer methods in treatment. The Canadian Nurse, 40, pp. 393-394). The editor discussed the discovery of and testing of penicillin (Editor. (1943). Further advances in the treatment of infections. Canadian Public Health Journal, 34, pp. 427-428; Gray, A. W. (1944). Penicillin. The Canadian Nurse, 40, pp. 17-21; Editor. (1945). The clinical use of penicillin. The Canadian Nurse, 41, pp. 58-59). In 1946, Dr. Smith explained the action of the latest antibiotic, streptomycin (Smith, F. (1946). Streptomycin and related phenomena. The Canadian Nurse, 42, pp. 295-296

> much attention to the preventive aspect of medicine. It is hardly conceivable that hospitals can remain behind in an expansive and popular program that has for its objective the maintenance of a positive health among the people of the community which it serves. [527]

A gallup poll in 1942 reported that 75% of Canadians wanted a national health plan for medical and hospital care sponsored by the government. [528] A national health program for Canada was announced on May 14, 1948 by Prime Minister Mackenzie King. The federal government provided grants for three areas: (a) health survey of provincial health needs, (b) public health programming, and (c) hospital construction. Public health programming grants included: (a) general public health programs, (b) tuberculosis, (c) mental health care, (d) venereal disease control, (e) crippled children's, (f) professional training, (g) public health research, and (h) control of cancer. This was the preliminary steps to a future health insurance program. This program increased by 30% all the money spent in Canada on health. Acknowledging that health was a provincial responsibility, Paul Martin emphasized the need for cooperation "to determine the mutually acceptable conditions to govern all grants." He went on to describe three progressive steps in the history of public health work in Canada: (a) "sporadic action against epidemics" which included action to

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[527] Macdonald, M. R. (1945). The future of the nurse in public health. The Canadian Nurse, 41, pp. 625-628.

[528] 18% did not want the plan and 7% were undecided (Fahrni, G. S. (1942). Medicine and the nation. The Canadian Medical Association Journal, 47, p. 72).

control disease through sanitation and quarantine; (b) preventive stage through sanitation, pasteurization and immunization; and (c) "ultimate goal of universal good health--that positive concept of total health that is defined in the constitution of the World Health Organization as 'a state of physical, mental, and social well-being, and not merely the absence of disease or infirmity.'" [529]

## Status of Women

During the 1940s progress for gender equality was once again facilitated by the war. Unlike nurses in the USA, Canadian nurses were granted official rank and commissions. [530] In the post war period however, many of the long suffering inequities were still apparent: nurses were still struggling for fair wages, and the average female worker was receiving far less income than her male counterpart. [531]

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[529] Martin, P. (1948). A national health program for Canada. Canadian Public Health Journal, 39, pp. 219-226.

[530] In 1942, nurses were granted official rank and commissions. Matron in Chief in Canada was Elizabeth Smellie who held the rank of colonel. Matron in Chief overseas at the outbreak of the war was Emma F. Pense. In 1942, Agnes C. Neill assumed the position. The first matron in chief of Department of Veteran's Affairs was Agnes J. Macleod (CNA. (1968). The leaf and the lamp. Ottawa: Author).

[531] The National Committee for Mental Hygiene reported that the average income of a male worker in Canada was $927.00 and of a female worker was $559.00 (Editor. (1940). A background of experience. The Canadian Nurse, 36, p. 75). In 1947, in an article in the CMA journal about a birth control symposium at the Royal Society of Medicine of London, the editor summarized, "The problem presents medical, social, legal, and religious aspects....There was admittedly a loss of fulfillment if a woman voluntarily deprived herself of all childbearing....If used not so much to

## Development of the Nursing Profession

### Autonomy

During the war the AARN gained a great deal of autonomy and status as a profession. This was evident in the many collaborative activities, particularly with governments and Commissions created by government to deal with pressing social and health issues arising from the war. In the post war period however, the autonomy of the AARN suffered considerably at the hands of the president of the UofA, Dr. Newton, and the Minister of Health, Dr. Cross. Both men frequently made decisions affecting the AARN without consultation. In contrast, the AHA was extending every courtesy to the AARN to ensure a good working relationship.

### Skill and Knowledge

With advancements in technology, [532] medical specialization, [533] and institutionalization [534] accelerating at

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limit as to space child-bearing, it was wholly good" (Editor. (1947). Birth Control. The Canadian Medical Association Journal, 57, p. 489).

[532] Editor. (1942). The new bread. The Canadian Medical Association Journal, 46, p. 479; Editor. (1942). Intragroup blood transfusion reactions. The Canadian Medical Association Journal, 46, p. 479; Penfield, W. (1942). Health insurance and medical education. The Canadian Medical Association Journal, 47, p. 523-528.

[533] Archer, A. E. (1943). The challenge to organized medicine. The Canadian Medical Association Journal, 49, pp. 77-82. "How are we to wisely control and direct our ever narrowing specialization? Will there be ever more and more specialists in constantly narrowing fields? Are we going to entirely segmentalize the practice of medicine? Or can the place and nature and importance and dignity of the work of the general practitioner be reestablished as the foundation of the Health Service" (p. 81).

alarming speeds during WWII, a large number of nurses had a difficult time adjusting to these changes. The nursing profession had to change its organizational and educational methods to meet the new expectations. [535] Some nurses advocated specialization in nursing as a direction for the future. [536] The editor of The Canadian Medical Association Journal wrote:

> Perhaps the most important factor may be mentioned...the state of public opinion. There are evidences that the people at large are becoming health-conscious. The newspapers are featuring more and more medical and public health items....Another indication of the change that has come over the public mind is seen in that whereas fifty years ago you could hardly persuade a patient to enter a hospital, for he

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[534] Mr. Cody suggested that a modern hospital meets a number of community needs: treatment of emergencies, care of the ill and maintenance of health, education of professionals, research in laboratories, leadership in preventive medicine and provision of social service (Cody, H. J. (1940). The contribution a hospital may make to its community. Canadian Hospital, 17(1), pp. 11-14); Dr. Jenkins congratulated Alberta on helping to control tuberculosis [TB] by providing free care of TB patients (Jenkins, R. B. (1939). The place of the hospital in public health work in Canada. Canadian Hospital, 16(11), p. 28, 49-50). Dr. Agnew suggested that hospitals would be used even more for diagnostic tests, treatment, and care. He thought that doctors might have offices in hospitals, more doctors might be on salary from hospitals, and doctors might have difficulty getting admitting privileges (Agnew, H. (1946). The role of the hospital in medical economics. The Canadian Medical Association Journal, 55, pp. 558-562).

[535] Connal, J. A. (1939). Are we sacrificing comfort and service for technical training? Canadian Hospital, 16(7), p. 27. J. Connal was an instructor in nursing at the Calgary General Hospital.

[536] Bernice, M. (1940). Will there be more specialization in bedside nursing. Canadian Hospital, 17(9), pp. 24-25.

> regarded this as practically signing his death warrant; now you can hardly keep him out. [537]

No significant progress was made in the development of educational programs for nursing specialization during this period. As a result of the pressures brought to bear by the government and the public, the AARN lowered its educational standards for entrance into nursing. However the association worked diligently to ensure its supervisory role over the registration of nurses.

Service Ideal and Code of Ethics

Rae Chittick, president of the CNA and past president of the AARN, in raising her concern for nursing's threatened values, discussed these ideas with clarity:

> Firstly, the dignity of the individual, and secondly, his responsibility....The idea of individual dignity implies respect for one's own personality and that of others....This respect does not necessarily mean admiration or approval for every person...but it does mean the recognition of every person's basic rights as a human being, an individual....As to the sense of individual responsibility....People have become accustomed to laying the blame somewhere else, placing the responsibility somewhere else, looking for help and guidance somewhere else. There is a widespread tendency not to set one's own standards, but to follow the standards set by others....We must accept each man (and woman) as a distinct personality and we must respect his uniqueness for he has a citadel which is sacred and is possessed of inviolable human rights. We must endeavor to restore responsibility to the

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[537] Editor. (1940). Medical science and social progress. The Canadian Medical Association Journal, 42, pp. 74-75.

> individual, for without individual responsibility society lacks stability and integrity. [538]

In another article, Rae Chittick discussed her ideas of the political right of human beings:

> Few of us can make more than the...most insignificant contribution to the society in which we live. But if our hearts are in our work, if we have faith that it is worth doing, we shall have a sense of participation in the great drama of human events; we shall occupy our own peculiar place in the world. We shall know where we are and whither we are tending; we shall be able to judge what to do and how to do it. [539]

Marion Myers stated a nurse had to possess, not only the attributes of a skilled artisan (efficient, confident, thrifty, and non-mechanical) and those of a professional (autonomous, responsible, and socially minded), but also, "the aesthetic qualities of an artist, whose aim and delight is perfection, whose sense of proportion and rhythm together with beauty of purpose (which is spiritual) elevates nursing to its original yet greatest possibility--that of a fine art." [540]

The continued strong affiliation of the nursing profession to Christianity was reaffirmed when the AARN agreed to the CNA suggestion that there be an annual vesper service so nurses could

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[538] Chittick, R. (1946). Our threatened values. The Canadian Nurse, 43, pp. 21-22.

[539] Chittick, Rae. (1948). On pulling weeds. The Canadian Nurse, 44, pp. 13-15.

[540] Myers, M. (1942). Our unique resources. The Canadian Nurse, 38, pp. 247-248.

re-dedicate themselves to nursing. [541] Nursing ended the decade without a written code of ethics. [542]

The growth and development of the AARN as a profession was obvious in its several collaborative relationships with other health care service agencies and its involvement in national and international nursing organizations. The AARN also invested much energy in attempting to maintain its standards for skill and knowledge. As a professional organization however, its autonomy was severely eroded in the most fundamental of ways: it was not extended recognition as a professional by the University of Alberta and the Minister of Health. As a result it had no outlet to affect health policy during this period. The AARN did have an impact on health care services through its collaborative relationship with the AHA, and directly through the work of its membership.

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[541] AARN. (April 6-7, 1942). Minutes. Edmonton, p. 537. A different church would be chosen each year.

[542] The ICN code was ratified in 1953 and the CNA adopted it soon after.

# Chapter VI

## Foundation for the Future

The AARN was the vision of a handful of nurses who believed nursing to be a worthy profession. From 1916 to 1950 this association confirmed its role as a professional member of the health disciplines. It encountered many challenges, perhaps rooted in gender inequity. Paternalistic attitudes of government officials, elected representatives, and physicians, all of whom were predominantly male, made it a struggle for nurses to gain and maintain autonomy as a profession.

Throughout the study period the AARN had little direct impact on health policy. In its early years, perhaps as it was trying to define its own priorities and perhaps as a result of the high level of general public concern, the AARN was more active in attempting to contribute in areas of health policy development. In later years the AARN only rallied around areas directly affecting nursing practice and nursing conditions. In this respect, its impact might be characterized as focusing on health care services from 1916 to 1950, rather than on health policy.

### Health Care Services and Health Policy

In the study period health care services and health policy reflected response to threats to the health of the public. As most health policy was the result of public demands, most of the policy formulation and health care service definition was determined by

the various levels of government. To have an impact on these matters required political knowledge and resources.

In 1867, the Canadian government had few powers related to health policies. With each decade these powers increased, with the most significant increase occurring in the 1930s. Three catalysts of health reform were epidemics of communicable diseases, social upheaval of the world wars, and economic depressions. The Alberta government frequently lead the way in health care reform through innovative programs. Sometimes it was forced into action when it identified successful initiatives of municipalities, especially in the first two decades of the 1900s. One of the first pieces of legislation of the first legislative sitting in Alberta was the creation and passing of a comprehensive public health program. In the 1920s and 1930s the provincial government provided much of the leadership and took more and more of the responsibility previously designated to municipalities. The change in responsibility and initiative was primarily due to the province's ability to finance the type of health care the public required and demanded. The federal government began to assume more responsibility for health care during the economic depression of the 1920s and the 1930s, when the municipalities and the provincial government no longer could bear the cost of the basic essential services required. The two world wars also significantly affected the involvement of the federal government in more direct relief or assistance to

increasing numbers of Canadian citizens. Those injured in the armed forces and their dependants, as well as the dependants of those killed during the wars, were added to the federal government's list of responsibilities. In the 1940s the federal government was able to influence decisions made by provincial governments due to its major role in cost sharing health programs.

## Status of Women

The majority of women did not have equal rights during the study period, notwithstanding enfranchisement in 1916 for Alberta women and in 1918 for Canadian women. In the late 1800s and first three decades of the 1900s various women's organization, particularly the NCWC and the Women's Institutes, made valuable contributions toward improving the health and social conditions of Canadians. Despite the valuable work of these groups there was little change in the social status of the majority of women in Canada. The work done by these women groups was often viewed as charity and volunteer work, thereby secondary in importance to "real" work. In 1929 women won the right to be called "persons" and be appointed to the Senate of Canada. During both world wars women competently filled the vacancies left by men going overseas, although they frequently received lower pay than men for the same work. Women were encouraged to return to their pre-war vocations as the armed

forces personnel returned to Canada. The women staying in the work force remained primarily in "female" jobs.

In the early years the AARN resisted opportunities to work collaboratively with the women's organizations involved in health and social programming. Occasionally, when a link was created, it seemed that the AARN made the choice for self-interested reasons, only upon assessing the potential benefits to itself. Throughout the study period few collaborative gestures were identified that focused on the good of the community first and the profession second. During WWII there was a marked change in the position of the AARN with regard to working with other groups. This appears to be largely due to the leadership style utilized by elected members of the AARN council from 1941 to 1945. In the post-war era there was no evidence of the AARN taking any major steps in working on issues relating to the status of women, other than those relating directly to its membership.

## Development of the Nursing Profession

The meaning nursing as a verb has remained quite similar since concisely articulated by Florence Nightingale in 1893. [543] In the mid 1930s, the discovery of the "Miracle or Wonder drugs" antibiotics, [544] had a significant affect on health care. The drugs

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[543] "To put the patient in the best condition for nature to act upon him" (Nightingale, F. (1861). Notes on nursing for the labouring class. London, JK:Pall Maall, p. 94.

[544] Paul Gelmo, Chemist, Germany in 1908 used as a dye (Lawson, D. E. (Ed.). (1976). Sulfa. The American educator (Volume 18). Lake Bluff, IL: United Educators, p. 560). This substance was not discovered to have

increased the speed of recovery, changing nursing from long arduous "hands on" caring that had been required in the past for patients' survival, to a more "hands off" caring where the nurse administrated medications, organized environments, and coordinated other health professionals. The meaning of nursing as a noun must be explored in the context of the evolution of the profession.

Autonomy

The AARN worked diligently to achieve the autonomy it required to secure its existence as a profession. Throughout its early years registration was a major focus for the association. It was only after many labours that it won the right to be the exclusive professional association of nurses in Alberta. One might have expected that status would have assured the autonomy of the AARN, but unfortunately it did not. At the conclusion of the study period the most significant threat to the AARN was the disregard of its autonomy by the UofA and the Minister of Health.

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medicinal uses until the early 1930s (Goetz, P. (Ed.). (1987). Sulfanilamide. Encyclopedia britannica (Volume 11). Toronto: Encyclopedia Britannica, p. 366). Penicillin was discovered in 1928 by Dr. Alexander. Fleming, a British bacteriologist. The drug was ignored until 1939 when Howard Walter Florey, a British pathologist from Oxford, extracted a crude penicillin and used it in treating patients. He brought it to the USA in 1941 (Lawson, D. E. (1976). Penicillin. The American Educator (Volume 15). Lake Bluff, IL: United Educators, p. 117). Alexander Fleming, Howard Florey and Ernest Chain, a German biochemist, received the Nobel prize in medicine and physiology in 1945 (Dorland's Medical Dictionary (25th ed.). (1974). Toronto: W. B. Saunders, pp. 294, 598, 599).

Skill and Knowledge

The knowledge and skill component of the nursing profession was a major focus of the AARN from 1916 to 1940. To ensure quality nursing care, a number of initiatives were taken. The entrance requirement to nursing was increased from grade VIII level to grade XII matriculation level and then lowered again to grade XI. The CNA standard curriculum was adopted for schools of nursing. An inspector of schools was engaged to ensure compliance with the standards of education and to ensure quality living and working conditions for nursing students. A standardized registration examination was developed for graduate nurses. Refresher courses were developed for graduate nurses, while post-RN courses were developed in a number of specialized areas. Nurses lobbied the UofA to provide a degree program in nursing and scholarships were provided to encourage nurses to pursue post-graduate level work.

The Weir Report was the most significant document in nursing history in Canada during the study period. Arguably it was also an important document in health care reform, setting the stage for other major studies. There was very little nursing theory and research done by 1950; however the importance of both was clearly recognized by the AARN and the CNA through its scholarship programs and other forms of encouragement to nurses to pursue post-graduate education.

Service Ideal and Code of Ethics

Most Albertan and Canadian nurses saw their practice as being guided by Christian values. [545] The emphasis on Christian values in the curricula of the schools of nursing was evident from 1916 to 1950. Part of the reason the AARN centred on these values may have been that the earliest hospitals were affiliated with religious orders of the Catholic church or with missionaries of the protestant sects. In the 1930s the revival of the social gospel movement infused socialistic and Christian values into the political and social sectors, which would have had an affect on the health sector and nursing. The AARN had not written its own code of ethics as of 1950. In 1953 it adopted the ICN code. While the code was written for an international association, its adoption by the AARN indicated it must have reflected the functions of nurses and the norms and values of the society at the time.

In conclusion, it would seem that the AARN had some influence on health care services but relatively little observable influence on health policy from 1916 to 1950 in Alberta. In its first decade the AARN concentrated on registering nurses and setting standards for membership. With the initiation of the Weir

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[545] Marsh, J. H. (Ed.). (1985). The Canadian encyclopedia. Edmonton: Hurtig, pp. 341-343. According to T. S. Faulkner Canada has been classified as a Christian country, but "since the 1950s there has been a significant shift away from Christian language in public life" (p. 342). "In the wake of WWII church leaders were confident in the strength of the churches: attendance at weekly services was high" (p. 343).

study, the AARN became more proactive but tended to focus on health policy that would affect the educational standards and working and living conditions of nurses. Except on very rare occasions, it did not make position statements as to health policy, but concentrated almost exclusively on attempts to ensure that its members were accepted as legitimate professionals of a worthy profession. It would seem to be a necessary part of the evolution of a profession to focus on the internal before it is possible to focus on matters external to the professional entity, such as health and social policies at local and global levels.

At the end of the study period a number of major initiatives related to health care services and health policy were considered. The response of the AARN to the socialization of medical, nursing and health care, to the increased specialization and technology, and to the changes in its professional role in respect to labour relations in the next twenty years presents a potentially fruitful area for further study. In this examination the status of women would seem to be an area requiring further investigation as the status of nursing appeared to be inextricably linked with the status of women. The curricula of the schools of nursing in Alberta would be a vital part of such a study. It appeared from a review of this time period that the philosophies of the more highly educated nurses educating undergraduates were affected significantly by the philosophies of the various disciplines in which they took their post graduate education. In any study about

nursing, it would be necessary to analyze the impact of other disciplines, particularly medicine, upon the nursing profession. The increased sophistication and education of the health care consumer would also seem to have a significant influence on health policy and health professionals, especially nurses.

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